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No. 80-1952

IN THE
Supreme Court of the United States
OCTOBER TERM, 1981

BARBARA BLUM, as Commissioner of the New York State Department of Social Services; DAVID AXELROD, M.D., as Commissioner of the New York State Department of Health,

Petitioners

against

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Respondents,

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Intervenors-Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

JOINT APPENDIX

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Petition for Certiorari Filed May 19, 1981
Certiorari Granted October 5, 1981

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Relevant Docket Entries in the United States District Court for the Southern District of New York

76 Civ. 3360 W. Yaretsky, et ano. v Phillip Toia [& Robert Whalen] [as amended 4-8-77] MOTLEY, J.

DATE	DOC. NO. [RECORD ON APPEAL]*	PROCEEDINGS
7-28-76	(1)	Filed complaint and issued summons . . .
		* * *
11-4-76	(3)	Filed marshal's return—served the following: Philip Toia by John Wylie on 10-26-76 J. Raymond Diehl by John Wylie on 10-26-76
		* * *
12-13-76	(4)	Filed ANSWER of defts. to the complaint. (L.J.L.)
		* * *
4-7-77	(6)	Filed pltff's (Ralph Cuevas) affdvt. to proceed in forma pauperis.
4-7-77	—	Filed memo endorsed on document #6 —that said pltff. is permitted to proceed in forma pauperis. MOTLEY, J.
		* * *
4-8-77	(8)	Filed first AMENDED COMPLAINT—issued summons.

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* The writ of certiorari granted in part by this Court on October 5, 1981 refers to an appeal designated by docket number 80-7197 in the United States Court of Appeals for the Second Circuit. The numbers in parentheses and brackets correspond with the document numbers in the 80-7197 Second Circuit record on appeal which will be transmitted to this Court. See Rules 23(2) and 30(2) of the Supreme Court Rules. The 80-7197 record on appeal includes records on appeal in earlier and later Second Circuit appeals in the same case which were designated as 78-7077 (earlier appeal, adjudicated) and 80-7559 with cross appeal 80-7625 (later appeals, withdrawn). Documents for the several appeals are identified by Second Circuit docket number when necessary to enhance clarity.—ED.

District Court Docket Entries

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
4-13-77	(9)	Filed Order that pltff. William Yaretsky is permitted to proceed in forma pauperis, etc. MOTLEY, J. (m/n)
		• • •
5-23-77	(10)	Filed ANSWER of defts. to the Amended Complaint. (L.J.L.)
		• • •
12-5-77	[12]	Filed Order to Show Cause with proposed intervenor complaint to show cause, temporary restraining order and joinder order, for preliminary injunction, etc. ret. 12-8-77. MOTLEY, J.
12-14-77	[13]	Filed [intervenor] complt.—class action [Birenzweig, etc.].
12-14-77	[14]	Filed brief in support of motion of pltff. for certification of subclass.
12-14-77	[15]	Filed Order to Show Cause for order to intervene, class certification and temporary restraining order ret. 12-20-77 at 2 PM. MOTLEY, J.
1-3-78	[16]	Filed affidavit of deft. in opposition to application for preliminary inj.
1-3-78	[17]	Filed affidavit of deft. in opposition to motion for preliminary inj.
1-5-78	[18]	Filed deft. Dept. of Health (Office of Health Systems Management) affidavit re: utilization review committee, etc. by DONALD B. DAVIDOFF, Asst. Dirc. of the Facility Surveillance Group.
1-5-78	[19]	Filed deft. New York State Department of Social Services affirmation

District Court Docket Entries

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
		in opposition to pltffs.' motion for class certification and a preliminary injunction by PETER MULLANY.
1-5-78	[20]	Filed deft. New York State Dept. of Social Services (Div. Medical Assistance) affidavit in opposition to pltffs.' motion for class cert. & prelim. injunc. by WILLIAM STEIBEL.
1-5-78	[21]	Filed state defts.' memorandum of law in opposition to pltffs.' motion for prelim. injunciton and class certification.
1-4-78		Hearing begun.
1-5-78		Hearing concluded. Judge issued preliminary inj. Opinion to be written from oral record.
		• • •
1-10-78	[23]	Filed Order that pursuant to Rule 21 FRCP above-entitled action is dismissed as against deft. J. HENRY SMITH and that defts. Barbara Blum, individually etc. et al. are enjoined and restrained pending a final determination of the action from determining [the transfers] any of the pltffs.-intervenors in this action, etc. as indicated. MOTLEY, J. m/n
1-10-78	[24]	Filed Opinion No. 46745 re: motion for preliminary injunction, motion for intervention, motion for class action determination, motion to dismiss. For all the foregoing reasons, an injunction will therefore issue enjoining defts., pending a final determination of this action. First, defts. will be

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
		enjoined, etc. as indicated. What pltffs. actually seek is certification of sub-class. For purposes of this motion for preliminary injunction, . . . that certification is granted etc. as indicated. The city deft.'s motion to dismiss is . . . granted. MOTLEY, J. m/n
1-11-78	[25]	Filed Order that in accordance with court's opinion the instant action is certified as a class action, all intervenor petitions are granted, and deft. J. Henry Smith, Commissioner of Social Services, NYC is dismissed from this action as a pty-deft. So Ordered, MOTLEY, J. m/n
1-16-78	[26]	Filed INTERVENOR COMPLAINT — Class action. (Rec'd this date.) [Foley]
1-16-78	[27]	Filed INTERVENOR COMPLAINT — Class action. (Rec'd this date.) [Wolper, etc.]
1-19-78	[28]	Filed deft. notice of motion and affidavit for order to amend Court order of 1-5-78 ret. 1-19-78 at 4:30 PM.
1-23-78	[32]	Filed memo end. on #29 . . . order will remain as is until new forms are submit[ted by] state defts. So ordered. MOTLEY, J.
1-27-78	[29]	Filed defts.' supplemental affidavit in support of motion to amend order dated 1-5-78.
2-6-78	[30]	Filed pltffs.' affidavit in opposition to defts.' present motion for amendment of partial stay of Court's order etc., by PHILIP M. GASSEL.

District Court Docket Entries

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
2-6-78	[31]	Filed NOTICE OF APPEAL [in 78-7077] of defts. Blum and Whalen to USCA 2nd Circuit from order dated 1-5-78 and opinion filed 1-10-78 granting pltffs.' motion for a preliminary injunction, etc. * * *
2-21-78	[29]	Filed memo end. . . . motion to amend order to permitting notice to be sent etc. denied. So ordered, MOTLEY, J. m/n
3-14-78	[33]	Filed transcript of proceedings dated 1-5-78.
2-17-78		PRE-TRIAL CONFERENCE HELD BY MOTLEY, J.
3-24-78	[34]	Filed notice to docket clerk of transmission of record to USCA [in 78-7077].
3-31-78	[35]	Filed defts.' objections to notice to produce.
4-17-78	[36]	Filed pltffs.' notice of motion and affidavit for order granting summary judgment ret. 4-24-78.
4-17-78	[37]	Filed pltffs.' memo in support of motion for partial summary judgment.
4-19-78	[38]	Filed pltffs.' 1st notice to produce.
4-20-78	[39]	Filed pltffs.' affidavit and notice of motion for an order to compel production of documents. ret. April 25th, 1978.
4-20-78	[40]	Filed pltffs.' memorandum of law in support of motion to compel production of documents.

* * *

District Court Docket Entries

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
5-8-78	[42]	Filed defts.' memo of law in opposition to pltffs.' motion for partial summary judgment.
5-8-78	[43]	Filed [affidavit] of J. Levy in opposition to motion for pltffs. for summary judgment.
5-8-78	[44]	Filed order compelling discovery and protective order. MOTLEY, J. Pltffs. are to recover reasonable attny's fees in connection with this matter etc. MOTLEY, J.
5-26-78	[45]	Filed transcript of record of proceedings dated 1-4, 5,-78.
5-26-78	[46]	Filed notice of transmission of 1st supplement to record on appeal [in 78-7077].
6-1-78	[47]	Filed defts.' objections to notice to produce.
6-2-78	[48]	Filed pltffs.' affidavit re: attny's fees in Rule 37 motion.
6-2-78	[49]	Filed pltffs.' reply memo in support of motion for summary judgment.
6-7-78	[52]	Filed pltffs.' affidavit and notice of motion for an order to compel production of documents, etc. ret. 6-7-78.
6-7-78	[53]	Filed pltffs.' memorandum in support of motion to compel production of documents.
6-7-78	[51]	Filed pltffs.' notice of motion for order to modify order of 5-4-78 . . . ret. 6-7-78.

District Court Docket Entries

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
6-6-78	[50]	Filed pltffs.' 2nd notice to produce.
6-15-78	[54]	Filed memorandum opinion #47307 re: the . . . award attorneys' fees to pltffs. in the amount of $1,260 etc. pur[suant to] FRCP 37 [a][4]. MOTLEY, J. m/n
6-21-78	[55]	Filed Order modifying the order of May 4, 1978 compelling discovery. MOTLEY, J. m/n.
6-21-78	[56]	Filed Order compelling the production of documents, protective order and order pursuant to FRCP Rule 37 (d). MOTLEY, J.
6-28-78	[57]	Filed stipulation that the following documents become part of the record on appeal [in 78-7077].
6-28-78	[58]	Filed notice of transmission of 2nd supplemental . . . record on appeal [in 78-7077].
7-5-78	[59]	Filed Opinion #47,385 . . . pltffs.' motion for declaratory judgment is granted . . . Motion for injunctive relief is denied . . . Submit order on notice and within 5 days of filing this opinion. MOTLEY, J. m/n
7-14-78	[60]	Filed defts.' notice of appeal to USCA from orders of J. Motley dated 6-15-78 and 6-21-78
		• • •
7-17-78	[61]	Filed defts.' memo of law in support of defts.' motion to vacate.
7-17-78	[62]	Filed pltffs.' notice of motion and affidavit for order awarding attny's fees to pltffs. ret. 8/1/78.

District Court Docket Entries

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
7-28-78	[63]	Filed pltffs.' memo in opposition to defts.' motion to vacate awards.
		* * *
8-7-78	[65]	Filed Partial Judgment . . . ordered that deft. Whalen formally promulgate the statements contained in Hospital Memo 77-9, 77-10 and 77-13 [as] required by State Adm. Procedure Act, etc. and that pltffs.' motion for inj. relief is denied with leave to renew. MOTLEY, J. Judgment ent. 8-7-78 Clerk.
8-15-78	—	Filed memo end on #6[2] . . . motion denied for all reasons urged by pltffs. So Ordered, MOTLEY, J. m/n.
		* * *
8-23-78	[66]	Filed pltffs.' first interrogs.
9-11-78	[67]	Filed pltffs.' notice of motion to impose sanctions for failure to comply with orders to compel production . . .
9-11-78	[68]	Filed pltffs.' memorandum in support of motion to impose sanctions . . .
9-12-78	[69]	Filed true copy of USCA order withdrawing appeal [doc. no. 60] with prejudice.
9-18-78	[70]	Filed deft. Atty General, State of New York's affidavit in opposition to pltffs.' motion to impose sanctions by: KEVIN J. MCKAY.
9-19-78		Filed memo endorsed on document No. 6[7] . . . Defts. have until 10-16-78 to fully comply with previous orders to produce. For failure to do so, sanctions will be imposed. So Ordered, MOTLEY, J. m/n

District Court Docket Entries

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
9-21-78	[71]	Filed pltffs.' third notice to produce.
		* * *
2-8-79	[74]	Filed true copy of USCA Order and opinion [in 78-7077] that judgment of U.S. Dist. Ct. is affirmed in accordance with the opinion of this Court with costs to be taxed against the appellants. JUDGMENT ENTERED — 2-8-79 — CLERK — ent. 2-9-79.
3-5-79	[75]	Filed pltffs.' pre-trial memorandum.
3-6-79	[76]	Filed Pre-Trial Order. MOTLEY, J.
4-3-79	[77]	Filed memo end. on letter to Judge Motley dtd. 3-23-79 — The foregoing proposed amendments to the last pre-trial order and stay are hereby granted. MOTLEY, J.
		* * *
9-14-79	[80]	Filed pltffs.' notice of motion for summary judgment ret. 9-21-79.
9-14-79	[81]	Filed pltffs.' memorandum in support of pltffs.' motion for summary judgment.
9-21-79	[82]	Filed pltffs.' supplemental affidvt. by P. M. Gassel in support of pltffs.' motion that court enter the parties' stip. of consent to entry [of] a partial final judgment.
9-24-79	[83]	Filed memo end. on letter to Judge Motley, dtd. 9-21-79—Defts.' Order to Show Cause will be heard together with pltffs.' outstanding motion on 10-15-79 at 2:00 pm. MOTLEY, J. m/n.
10-1-79	[84]	Filed pltffs.' supplemental memorandum in opposition to defts.' OSC and

District Court Docket Entries

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
		in further support of pltffs.' motion for final judgment.
10-3-79	[85]	Filed memo end. on defts.' Order to Show Cause why an order should not be made joining the U.S. Dept. of HEW as a party . . . — After hearing on 10-3-79, both sides present, the court denied the application of the defts. to make HEW a party to this action. The motion for summary judgment which was filed by pltffs. on 9-14-79 will be heard on 10-17-79 at 4:30 p.m. The defts. are directed to serve and file an ans. to the motion on 10-10-79. The pltffs. shall serve and file . . . on or before 10-15-79. . . . MOTLEY, J. m/n.
10-10-79	[86]	Filed defts.' affdvt. of K.A. Thomas in opposition to pltffs.' motion for summary judgment.
10-10-79	[87]	Filed defts.' memorandum of law in opposition to pltffs.' notice of motion.
10-15-79	[88]	Filed pltffs.' reply memorandum in support of summary judgment.
10-19-79	[89]	Filed PARTIAL FINAL JUDGMENT — Ordered that the stip. of consent to entry of partial final judgment, with addendum concerning monitoring, annexed hereto is the judgment of this Ct. MOTLEY, J. JUDGMENT ENTERED 10-19-79—CLERK ent. 10-22-79. m/n
10-19-79	—	Filed memo end. on doc. #8[2]—The Court holds that as to both . . . transfers out of a facility or to a lower

District Court Docket Entries

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
		level of care and as to U R transfers to higher levels of care there is a due process right to a hearing, state action being involved in both instances for all of the reasons set forth in pltffs.' memorandum of law on these question[s] and that it is settled law that a . . . transcript is required. Submit Order. MOTLEY, J. m/n
10-17-79	*[96]	Filed deposition/examination before trial of Henry Stevenson witness on behalf of the defts., taken by pltffs. on 11-21-78.
10-17-79	*[97]	Filed deposition/examination before trial of Philip Nostramo, witness on behalf of the defts., taken by pltffs. on 12-5-78.
10-17-79	*[98]	Filed deposition of Anthony J. Maddaloni taken by pltffs. on 10-26-78.
10-17-79	*[99]	Filed deposition of New York State Dept. of Social Services, by Richard Ruid taken by pltffs. on 10-27-78.
10-17-79	*[101]	Filed deposition of non-party witness David Glasser, taken by pltffs. on 11-20-78.
10-17-79	*[100]	Filed deposition of Roger C. Herdman, M.D., taken by pltffs. on 12-15-78.
11-19-79	*[95]	Filed pltffs.' deposition of the non-party witness Elizabeth Dinehart on 11-22-78.

* Numbers in brackets preceded by an asterisk correspond with the document numbers in the first supplemental record on appeal to the United States Court of Appeals for the Second Circuit in 80-7179.—ED.

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
2-14-80	[90]	[Filed] PARTIAL FINAL JUDGMENT—Ordered that the pltff. class in this action is defined as all Medicaid recipients in the State of N.Y. . . . Ordered that deft. State Commissioner of Social Services and her authorized agents are perm. inj. and that the defts., their officers, et al. are perm. inj. . . . as indicated . . . and that the issue of pltffs.' entitlement to an award of reasonable atty's fees, expenses and costs is reserved for later determination by this Court upon appropriate motion. MOTLEY, J. JUDGMENT ENT. 2-19-80—CLERK—ent. 2-20-80. m/n
3-7-80	[91]	[Filed] defts.' notice of appeal to USCA for the 2nd Circuit [in 80-7197] from partial final judgment ent. 2-14-80 granting summary judgment in favor of pltffs. on the reserved legal issues. (3-10-80 mailed copies to PHILIP M. GASSEL, Legal Services, 2095 Broadway, Rm 304., New York, N.Y. 10023., Charles Robert, Nassau Action Coalition, 40 Washington Street, Hempstead, New York 11550., Kalman Finkel, 11 Park Place 8th Floor, New York, N.Y. 10007., David Goldfarb, 953 Southern Blvd., Bronx, N.Y. 10459., Joan Mangones, Ann Moynihan, 42 Richmond Terrace, Staten Island, N.Y. 10310.)
—	*[102]	Clerk's certificate for first supplemental record on appeal. Entry omitted by district court.—ED.°

° Document number [102] concludes the record on appeal and first supplemental record on appeal to the United States Court of Appeals for the Second Circuit in 80-7197.

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
3-27-80	103	[Filed] pltffs.' brief in support of its motion for supplemental order and inj. and for finding of civil contempt.
3-27-80	104	[Filed] pltffs.' affdvt. and notice of motion for supplemental order and inj. and for finding of civil contempt.
4-8-80	105	[Filed] notice that original record on appeal [in 80-7197] has been cert. and trans. to the U.S.C.A. for the 2nd. Circuit, this day.
4-15-80	106	[Filed] defts.' affdvt. and notice of cross motion for stay pending appeal [in 80-7197] ret. 4-16-80.
4-15-80	106	[Filed] defts.' affdvt. by K.A. Thomas in opposition to pltffs.' motion for supplemental order and inj.
4-15-80	107	[Filed] defts.' brief in opposition to pltffs.' motion for supplemental order and for finding of civil contempt and in support of defts.' cross motion for stay pending appeal.
4-16-80	108 †[108]	[Filed] motion by attys for proposed intervenors to intervene as defts. . . . ret. 4-16-80.
4-16-80	109 †[109]	[Filed] memorandum in support of motion to intervene.
4-18-80	110	[Filed] pltffs.' reply and ans. brief in further support of pltffs.' motion for

† Numbers in brackets preceded by † correspond with the document numbers in the record on appeal to the United States Court of Appeals for the Second Circuit in 80-7559 (with cross-appeal 80-7625). The 80-7559 record on appeal contains District

(footnote continued on following page)

District Court Docket Entries

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
		supplemental order and inj. and for a finding of civil contempt.
		• • •
4-18-80	113 †[112]	[Filed] defts.' demand for hearing with respect to pltffs.' motion dtd. 3-25-80 and order finding defts. in civil contempt.
5-7-80	114	[Filed] pltffs.' notice of motion for additional supplemental order and injunction.
5-7-80	115	[Filed] pltffs.' brief in support of . . . motion for additional supplemental order and inj.
5- 9-80	116 †[113]	[Filed] Order that the motion of the applicants for intervention to intervene as parties deft. . . . is granted and that deft-intervenors are to submit their papers in opposition to pltffs.' motion by 5-15-80. MOTLEY, J. m/n
5-15-80	117	[Filed] deft-intervenors' brief in opposition to pltffs.' motion.
5-15-80	118	[Filed] deft-intervenors' affdvt. by M. Rosenblatt.

(footnote continued from preceding page)

Court proceedings which are subsequent to the judgment on appeal in 80-7197. The Clerk of the Court of Appeals, nonetheless marked the 80-7559 record on appeal as the second supplemental record on appeal in 80-7197. He will be asked to transmit the 80-7559 record on appeal to this Court, marked as the second supplemental record on appeal in 80-7197, so that the documents will be available if the parties refer to them, and the Court accepts those refeernces as appropriate.—ED.

District Court Docket Entries

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
6-5-80	119	[Filed] stipulation that . . . document become part of the record on appeal.
6-5-80	120	[Filed] certified [first supplemental] record on appeal [in 80-7197].
6-10-80	121 †[114]	[Filed] Order that each & every Long-Term Care Memo of Understanding entered into * * * which does not include paragraphs II, III, & IV of the partial final judg. is invalid & null, etc. Defts. are restrained from signing & entering into any Memo of Understanding concerning review of long-term care * * * Motion #114 denied, & defts.' motion for a stay pending appeal is denied . . . MOTLEY, J. m/n
6-10-80	122 †[115]	[Filed] Memo Opinion #50169 . . . Court concludes that pltffs.' motion #103 is granted, pltffs.' motion #114 is denied and defts.' motion for a stay pending appeal must be denied. So Ordered, MOTLEY, J. m/n
6-16-80	123 †[116]	[Filed] Order that the action is DISCONTINUED [; final judgment having been entered]. MOTLEY, J. m/n
7-9-80	124 †[117]	[Filed] N/A to the USCA [in 80-7559] by the defts. from the order dated 6-9-80 & entered 6-10-80. * * *
7-23-80	125 †[118]	Filed Notice of Cross Appeal [in 80-7625] by defts.-intervenors to the USCA from the order entered 6/9/80 ***

* * *

District Court Docket Entries

DATE	DOC. NO. RECORD ON APPEAL	PROCEEDINGS
10-1-80	127	[Filed] true copy of stip. from the USCA 2nd Circuit . . . that the appeal [in 80-7559] & cross appeal [in 80-7625] may be dismissed . . . Clerk USCA
		• • •
3-3-81	137	[Filed] true copy of Order from the USCA [in 80-7197] that the judgment of USDC is affirmed in part, vacated in part & modified & action is remanded to USDC for further proceedings in accordance with the opinion of this court . . . Clerk, USCA m/n
		• • •

Relevant Docket Entries in the United States Court of Appeals for the Second Circuit

Case No. 80-7197 Judge Motley Calendar Number 1234

DATE	FILINGS—PROCEEDINGS
3-12-80	Copies of district court docket entries and notice of appeal filed on behalf of Blum et ano.
	• • •
4-8-80	Record on appeal filed (original papers of district court).
	• • •
4-29-80	Appellant Blum et al brief filed, pfs (by mail).
4-29-80	Appellant Blum et al joint appendix filed, pfs (by mail).
5-7-80	Appellee Yaretsky et al brief filed, pfs.
5-20-80	Appellant Blum et al reply brief filed, pfs.
6-5-80	Appellant Blum et al motion for leave to file supplemental joint appendices filed, pfs. (Order endorsed 6-6-80 granting motions as to documents presently part of the record on appeal. Otherwise denied).
6-6-80	Appellant Blum et al supplemental joint appendix filed, pfs.
6-9-80	First supplemental record on appeal filed.
6-11-80	Case argued before: Lumbard, Mansfield, CJJ, Mehrtens, DJ.
8-25-80	Judgment affirmed in part, vacated in part and modified by published, signed opinion, Lumbard, C.J.
8-25-80	Judgment filed.
9-5-80	Appellees Yaretsky et al petition for rehearing filed, pfs.
9-8-80	Appellant Blum et al petition for rehearing filed, pfs.

Court of Appeals Docket Entries

DATE	FILINGS—PROCEEDINGS
	Appellant Blum et al petition for rehearing en banc filed, pfs.
9-24-80	Order denying appellees Yaretsky et al petition for rehearing filed.
12-8-80	Notice of filing of petition for writ of certiorari filed [by appellees]. (post card)
2-18-81	Order denying appellant Blum's petition for rehearing with suggestion for rehearing en banc filed.
2-26-81	Mandate (Opinion, Judgment) issued.
2-26-81	Certified copy of order of Supreme Court denying petition for writ of certiorari filed [by appellees].
6-26-81	Notice of filing of petition for writ of certiorari filed [by appellants]. (post card)
10-9-81	Certified copy of order from Supreme Court granting petition for writ of certiorari filed [by appellants] (S.C. #80-1952, Blum).
10-16-81	Original record on appeal received.
10-16-81	First supplement record on appeal received.
10-16-81	Second supplement record on appeal received.

First Amended Complaint

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

76 Civ 3360 (Motley)
FIRST AMENDED COMPLAINT
(Class Action)

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Plaintiffs,

—against—

PHILIP L. TOIA, individually and as Commissioner of the New York State Department of Social Services; and ROBERT A. WHALEN, M.D., individually and as Commissioner of the New York State Department of Health,

Defendants.

I. DESCRIPTION OF THE ACTION

1. This is an action by and on behalf of nursing home residents in the State of New York, eligible for or receiving Medical Assistance (Medicaid) benefits, who have been, are or will be threatened or forced to leave their nursing homes and have their Medicaid benefits reduced or terminated as a result of "Utilization Review" committee findings alleging that they are not eligible for the level of nursing home care they receive. Plaintiffs allege that, as it presently operates in nursing homes in New York State, this process of "Utilization Review" leading to involuntary transfer and reduction in Medicaid assistance is arbitrary and capricious, lacks adequate criteria, fails

to comply with legal requirements and procedural safeguards necessary for plaintiffs' protection and deprives plaintiffs of meaningful opportunity to contest proposed transfers and reductions in assistance. Plaintiffs seek declaratory and injunctive relief and damages to redress violations of rights secured to plaintiffs by Title XIX (Medicaid) of the Social Security Act, 42 U.S.C. § 1396, *et seq.*, and by the due process clause of the Fourteenth Amendment to the United States Constitution and 42 U.S.C. § 1983.

II. Jurisdiction

2. Jurisdiction is conferred upon this Court by 28 U.S.C. § 1331, and 28 U.S.C. § 1343(3) and (4). The amount in controversy, exclusive of interests and costs, exceeds $10,000. Declaratory relief is authorized by 28 U.S.C. §§ 2201 and 2202, and Rule 57 of the Federal Rules of Civil Procedure.

III. Plaintiffs

3. Plaintiff William Yaretsky is an American citizen, eighty-nine (89) years of age, residing at the American Nursing Home in New York, New York. Plaintiff Yaretsky, who has lived most of his life on the "lower east side" of Manhattan, has resided in the American Nursing Home (which is located in that neighborhood) for the past two and a half years. He is a recipient of Medical Assistance, pursuant to 42 U.S.C. § 1396, *et seq.*

4. Plaintiff Ralph Cuevas is an American citizen, seventy-seven (77) years of age, residing at the American Nursing Home in New York, New York. Plaintiff Cuevas, who has lived most of his life in the vicinity of the "lower

east side" of Manhattan, has resided in the American Nursing Home (which is located in that neighborhood) for the past seven and a half years. He is a recipient of Medical Assistance benefits, pursuant to U.S.C. § 1396, *et seq.*

5. Plaintiff GRAY PANTHERS, New York Chapter, is an unincorporated association in New York State of over 5,000 affiliated persons, having its principal office at 15 West 65 Street, New York, New York. The association includes many elderly persons who reside in nursing homes, and who are supported by Medicaid. The GRAY PANTHERS, New York Chapter, has among its objectives the development of a health care system for the elderly which provides quality health care to all persons regardless of their wealth or poverty and engages in activities to achieve this goal.

6. GRAY PANTHERS, New York Chapter, members have been injured in that they are, have been or will be involuntarily transferred or threatened with involuntary transfer from their nursing homes as a direct result of the unlawful acts and practices complained of herein.

7. As an organization, the purpose of the GRAY PANTHERS, New York Chapter, is thwarted and its operations obstructed as a direct result of the unlawful acts and practices complained of herein in that it is prevented from engaging in meaningful advocacy on behalf of its members, it is thwarted from achieving its goal of a quality health care system for the elderly regardless of their wealth or poverty, and it is impaired in its ability to engage in activities in furtherance of that goal.

IV. Defendants

8. Defendant Philip L. Toia, is the Commissioner of the New York State Department of Social Services. In that capacity, he is responsible for the administration of the entire Public Assistance program, including the Medical Assistance program, in the State of New York.

9. Defendant Robert A. Whalen, M.D., is the Commissioner of the New York State Department of Health. In that capacity, he is responsible for administration of certain aspects of the Medical Assistance program in the State of New York, and for licensing and supervising the operations of nursing homes in the state.

V. Class Action Allegations

10. The individual plaintiffs and plaintiff Gray Panthers bring this action on their own behalf and on behalf of all of those similarly situated, pursuant to Rule 23(a) and (b)(2), and of the Federal Rules of Civil Procedure. The class is composed of all persons in the State of New York who have, are or will: (a) reside in nursing homes (including "Skilled Nursing Facilities" and "Health Related Facilities"); (b) receive Medicaid assistance (42 U.S.C. § 1396, *et seq.*); and (c) be threatened or forced to leave their nursing homes and have their Medicaid benefits reduced or terminated as a result of determinations by defendants, based on "Utilization Review" committee findings alleging that plaintiffs are not eligible for the level of nursing home care they receive.

11. The class is so numerous that joinder is impracticable. Upon information and belief there are more than 1000 members of the plaintiffs' class. There are ques-

tions of law and fact which are common to the entire class. The claims of the representative plaintiffs are typical of the claims of the class. The representative plaintiffs are qualified to and will adequately protect the interests of the class. The defendants have acted or refused to act on grounds generally applicable to the class, and injunctive relief is appropriate for the class as a whole.

VI. Facts

A. *Generally*

12. Title XIX of the Social Security Act, 42 U.S.C. § 1396, *et seq.*, provides federal funds to states which choose to provide medical assistance to persons unable to afford adequate medical care. A state need not participate in the Medical Assistance (Medicaid) program, but if it does so it must conform to the requirements of federal law.

13. The State of New York, through the New York State Departments of Social Services and Health and other state and local agencies, operates a Medical Assistance (Medicaid) program under which, *inter alia*, it pays the cost of care in "Skilled Nursing Facilities" and "Health Related Facilities" (referred to collectively herein as "nursing homes") for eligible persons without sufficient income or resources to pay for their own care. N.Y. Social Services Law § 364-365-a.

14. As a precondition to the receipt of federal funds for the Medicaid program, the defendants are required to file a "state plan for medical assistance" with the Secretary of Health, Education and Welfare. The plan must include a provision for periodic review of all Medicaid

patients in nursing homes to determine whether they are appropriately placed and continue to require the level of nursing home care they receive. 42 U.S.C. §§ 1396, 1396a (a)(26) and (31); 45 C.F.R. §§ 250.19, 250.23, 250.24.

15. To carry out this review, federal and state regulations require that Utilization Review committees be established for each nursing home in New York State. It is the function of these committees to evaluate the continued need of each patient for the level of nursing home care he or she receives. Patients are to be reviewed in this manner, generally every 90 days. In general, the committee are to be made up of physicians and other professionals who are not employees of, or financially interested in, the nursing home, and who are not directly responsible for the patients' care. Each Utilization Review Committee operates independently of its counterparts in other nursing homes. 45 C.F.R. §§ 250.19.(a)(3) & (4), 250.23, 250.24; 10 N.Y.C.R.R. §§ 731.11 and 741.14.

16. In a case where the Utilization Review Committee's recommendation is that the patient does not require the level of nursing home care he receives, the nursing home, attending physician, patient and next of kin are to be notified in writing of the Committee's finding. Notice of the finding is also to be given to an official under control and direction of the defendant who is responsible for making decisions regarding the patient's Medicaid eligibility and payment. 45 C.F.R. §§ 250.19.(a)(3) & (4), 250.24, 250.24 [sic]; 10 N.Y.C.R.R. §§ 731.11 and 741.14. These decisions are generally made by the Department of Social Services of the city or county where the patient resides.

17. The policy and practice of defendants (or an official or agency under their control or direction) is to

make a determination that the patient is not eligible for Medicaid payments for the level of nursing care he is receiving, simply by adopting the findings of the Utilization Review Committee.

18. The current policy and practice of the New York State Department of Health is that most nursing homes are licensed to provide only a single level of care, either as "Skilled Nursing Facilities" or as "Health Related Facilities". Thus, for most patients the practical effect of a determination by defendants that the patient is ineligible for Medicaid payments for his current level of care, is to force the patient to leave his nursing home.

19. Defendants require that their decision, based on the Utilization Review Committee findings, be implemented by the patient accepting discharge from the nursing home and transfer to a facility offering a lower level of care or to the community. If the patient refuses to be transferred, defendants require that the patient's Medicaid benefits be terminated. If the patient requests a "fair hearing" to contest defendants' determinations, Medicaid benefits are continued pending the outcome of the hearing, (45 C.F.R. § 205.10 and 18 N.Y.C.R.R. § 358) thus permitting the patient to remain at the nursing home during this period.

B. *Plaintiffs* YARETSKY *and* CUEVAS

20. Plaintiffs YARETSKY and CUEVAS are, and have been for a period of years, recipients of Medicaid which finances the costs of plaintiffs' care in the American Nursing Home, a skilled nursing facility.

21. In or about December, 1975, recommendations were made to the New York City Department of Social Services following a review of their status at the American

Nursing Home, that plaintiffs YARETSKY and CUEVAS were no longer in need of, and therefore no longer eligible for, care in a skilled nursing facility. The New York City Department of Social Services administers the Medicaid program in New York City and is under the control and direction of defendant TOIA.

22. On information and belief, an employee of the American Nursing Home requested administrative hearings for plaintiffs YARETSKY and CUEVAS, who were physically brought to the hearings which were held on February 27, 1976.

23. On March 30, 1976, defendant TOIA issued Decisions After Fair Hearings directing that plaintiffs' YARETSKY and CUEVAS Medicaid benefits be terminated unless they accepted transfer to a "health related facility" providing a reduced level of nursing home care. Therefore, the transfer is a decrease in the Medicaid benefits of plaintiffs YARETSKY and CUEVAS.

24. On June 14, 1976, plaintiffs YARETSKY and CUEVAS requested that defendant TOIA set aside the decisions and schedule a new hearing. On July 23, 1976, this request was denied.

VII. FIRST CAUSE OF ACTION

25. Plaintiffs repeat and reallege each and every allegation set forth in paragraphs 12-24.

26. The plaintiffs make (made or will make) their homes in nursing homes in New York State where they receive (received or will receive) Medicaid assistance to pay for part or all of their care. Most nursing home patients reside in their nursing homes for several or more

years and most know no other home. Many of the plaintiffs have lived in the communities in which their nursing homes are located for much of their lives.

27. Through the operation of the "utilization review" and related administrative processes described in paragraphs 14-19 above, plaintiffs were or will be determined by defendants to be ineligible to remain in their present nursing homes and are, were or will be threatened with involuntary transfer from their nursing homes and with reduction or termination of their Medicaid assistance.

28. In addition, these patients are, were or will be exposed to a phenomenon injurious to their lives, health and well-being known as "transfer trauma", as a result of being uprooted from their homes and communities.

29. The utilization and medical review process in New York for assessing plaintiff's eligibility for their level of nursing home care, and the related administrative processes by which defendants affirm, review and implement these adverse eligibility determinations, operates without adequate, appropriate or uniform standards and criteria.

30. As a result, the entire decision process and the decisions of plaintiffs' ineligibility based on Utilization and Medical Review Committee findings, are arbitrary and capricious.

31. Furthermore, plaintiffs are thereby deprived of a meaningful opportunity for administrative or judicial review of adverse determinations.

32. In particular, the needs of plaintiffs YARETSKY and CUEVAS to remain in their skilled nursing facility were not

evaluated against previously approved written criteria developed by a properly constituted Utilization Review Committee.

33. Also, with regard to plaintiffs YARETSKY and CUEVAS, defendants failed to adhere to standards set forth in Title XIX of the Social Security Act and in applicable regulations for evaluating these plaintiffs' needs to remain in their skilled nursing facility.

34. As a result of defendants' failure, defendants' determinations (described in paragraphs 21-24 above) were contrary to the health needs of plaintiffs YARETSKY and CUEVAS and to professionally recognized standards of care.

35. Defendants thus violate:

(a) 45 C.F.R. § 250.19(a)(3) and (4) in that level-of-care determinations are not evaluated against adequate written criteria;

(b) 45 C.F.R. § 250.18 in that the defendants have failed to adequately monitor and supervise the utilization review process in nursing homes and to insure its effectiveness;

(c) 42 U.S.C. § 1396a(a)(3) in that defendants deprive plaintiffs of a meaningful opportunity for review of adverse determinations of eligibility for nursing home care;

(d) 42 U.S.C. § 1396a(a)(17) in that defendants have failed to include reasonable standards for determining eligibility for and the extent of medical assistance;

(e) 42 U.S.C. § 1396a(a)(19) in that defendants have failed to provide necessary safeguards to insure

that eligibility is determined in a manner consistent with the best interests of the plaintiffs;

(f) plaintiffs' rights to due process under the Fourteenth Amendment to the United States Constitution in that the defendants' decision process, and decisions of ineligibility based on utilization review findings are arbitrary and capricious, and that plaintiffs are deprived of a meaningful opportunity for review of these decisions;

(g) 42 U.S.C. § 1983 in that, under color of law, defendants violated plaintiffs' due process and other federal rights, and/or knew or should have known about such violations but permitted or failed to prevent such violations.

VIII. Second Cause of Action

36. Plaintiffs repeat and reallege each and every allegation set forth in paragraphs 12-24.

37. Defendants permit Utilization Review Committees, whose determinations form the basis for defendants' decisions requiring plaintiffs to be transferred from their nursing homes, to operate in violation of the requirements of 45 C.F.R. §§ 250.19(a)(3) and (4), including, *inter alia*, requirements regarding: (a) the composition of committees, (b) opportunity for comment by the patient's physician, and (c) notice to plaintiffs and others of the Committees' findings.

38. In particular, the needs of plaintiffs Yaretsky and Cuevas to remain in the skilled nursing facility were not reviewed by a properly constituted Utilization Review Committee, and their attending physician was not given

an opportunity to submit his views prior to recommendations having been made regarding these plaintiffs' continued residence and care in the skilled nursing facility.

39. Defendants thus violate:

(a) 45 C.F.R. § 250.18 in that they have failed to adequately monitor and supervise the operation of these committees;

(b) 42 U.S.C. § 1396a(a)(19) in that they have failed to provide necessary safeguards to insure that eligibility is determined in a manner consistent with the best interests of plaintiffs;

(c) 42 U.S.C. § 1983 in that, under color of law, knew or should have known that plaintiffs' due process and other federal rights were violated but permitted, or failed in their duty to prevent such violations.

IX. Third Cause of Action

40. Plaintiffs repeat and reallege each and every allegation set forth in paragraphs 25-28.

41. Defendants have failed to adopt policies and procedures under which nursing homes are licensed and required to provide for multiple levels of care within each facility. Such a policy would render it generally unnecessary to involuntarily transfer a patient found to be ineligible for the level of care he or she had been receiving.

42. Defendants thus violate 42 U.S.C. § 1396a(a)(19) in that they have failed to provide necessary safeguards to insure that eligibility is determined and care provided in a manner consistent wtih simplicity of administration and the best interests of the plaintiffs.

X. Fourth Cause of Action

(Plaintiffs Yaretsky and Cuevas only)

43. The plaintiffs repeat and reallege each and every allegation set forth in paragraphs 12-24.

44. At the time of the recommendations of the New York City Department of Social Services that plaintiffs Yaretsky and Cuevas did not require skilled nursing care, defendants failed to advise plaintiffs Yaretsky and Cuevas adequately of the recommendations or of their meaning.

45. Defendants also failed to advise plaintiffs Yaretsky and Cuevas of their right to contest these recommendations in an administrative hearing, and, at such a hearing, to be represented by counsel, to present evidence in opposition to these recommendations, and to confront any evidence to be offered in support of these recommendations.

46. Defendants' failures, as alleged in paragraphs 44 and 45, are particularly egregious in light of the special circumstances connected with plaintiffs' advanced ages and decreased capabilities.

47. Although physically present at the administrative hearings held on February 27, 1976, plaintiffs Yaretsky and Cuevas were unable to participate in any meaningful way due to defendants' failures as alleged in paragraphs 44 and 45.

48. With regard to plaintiffs Yaretsky and Cuevas, defendants thus violated:

(a) 45 C.F.R. § 205.10(a) which requires such notice and opportunity for hearing;

(b) rights secured to plaintiffs Yaretsky and Cuevas by the Fourteenth Amendment to the United

States Constitution which guarantees their right to due process of law prior to a decrease in their Medicaid benefits;

(c) 42 U.S.C. § 1983 in that, under color of law, they violated the due process and other federal rights of plaintiffs YARETSKY and CUEVAS, and/or know or should have known of such violations but permitted or failed to prevent such violations.

XI. IRREPARABLE INJURY

49. Plaintiffs are severely and irreparably injured in that defendants' actions subject them to arbitrary and illegal decreases in their Medicaid benefits, changes in their pattern of medical care, and "transfer trauma". Plaintiffs have no adequate remedy at law.

XII. PRAYER

WHEREFORE, plaintiffs pray on behalf of themselves and all others similarly situated that this Court:

1. assume jurisdiction of this cause;

2. certify the class of plaintiffs pursuant to Rule 23(c)(1) of the Federal Rules of Civil Procedure;

3. enter a judgment declaring that defendants have:

(a) violated plaintiffs' rights under the Due Process Clause of the Fourteenth Amendment to the United States Constitution, 42 U.S.C. § 1983, 42 U.S.C. § 1396a(a) and 45 C.F.R. § 250.18 and 19;

(b) violated plaintiffs' rights in that the recommendations, and decisions concerning plaintiffs' eligibility to

remain in their nursing homes are not in the interests of plaintiffs' health needs, or consistent with professionally recognized standards of health care;

(c) violated plaintiffs' rights by conducting an illegal, arbitrary and capricious utilization review process, and by rendering decisions in reliance on that process, in violation of applicable federal regulations and due process of law;

(d) violated the rights of plaintiffs YARETSKY and CUEVAS as set forth in 45 C.F.R. § 205.10(a);

4. enter preliminary and permanent injunctions enjoining the defendants, their agents and successors, from transferring or requiring the involuntary transfer of any members of the plaintiffs' from his or her nursing home or decreasing or terminating the Medical Assistance benefits of any member of the plaintiff class unless and until defendants comply with all of the legal requirements due to plaintiffs;

5. order the defendants to pay damages to those members of the plaintiff class, or their heirs, who are, were or will be involuntarily transferred from their nursing homes and whose Medical Assistance benefits have been decreased or terminated as a result of defendants' unlawful acts, in the amount of one million dollars ($1,000,000.00);

6. grant plaintiffs their costs and reasonable attorneys fees;

7. grant such other and further relief as may be just and proper.

DATED: New York, New York
February 9, 1977

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Answer to Amended Complaint

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

[Title omitted in printing.]

Defendants, Philip L. Toia and Robert A. Whalen, by their attorney, LOUIS J. LEFKOWITZ, Attorney General of the State of New York, for their answer to the amended complaint herein allege as follows:

FIRST: Deny the allegations contained in paragraph "1" in so far as the allegations therein may be construed to allege that defendants violated any right of any plaintiff, or that this court has jurisdiction of the action, or that this action is authorized by 42 U.S.C. § 1983.

SECOND: Admit the allegations contained in paragraphs "3" and "4", except deny knowledge or information sufficient to form a belief as to the truth or accuracy of the statement that Yaretsky and Cuevas have lived most of their lives on the lower east side of Manhattan.

THIRD: Deny knowledge or information sufficient to form a belief as to the truth or accuracy of the statements contained in paragraph "5".

FOURTH: In reference to paragraph "8", admit that Philip L. Toia is the Commissioner of the New York State Department of Social Services and respectfully refer this Court to the appropriate published statutes and regulations

for a true and accurate statement of defendant Toia's responsibilities and duties.

FIFTH: In reference to paragraph "9", admit that Robert A. Whalen, M.D., is the Commissioner of the New York State Department of Health and respectfully refer this Court to the appropriate published statutes and regulations for a true and accurate statement of defendant Whalen's responsibilities and duties.

SIXTH: Deny the allegations contained in paragraphs "12", "13", "14", "15" and "16", and respectfully refer this Court to Title 19 of the Social Security Act, 42 U.S.C. § 1396, *et seq.* and the relevant federal and state statutes and regulations for a true and accurate description of New York's plan for medical assistance and the operation of Utilization Review Committee, and the true meaning of the statutes and regulations cited therein by plaintiffs.

SEVENTH: Admit the allegations contained in paragraph "19", except deny that defendants' decision concerning the patient's need for a certain level of care is based solely on the findings of the Utilization Review Committee and respectfully refer this Court to the statutes and regulations cited therein for the true meaning thereof, and affirmatively allege that defendants implement federal regulations and requirements.

EIGHTH: Admit the allegations contained in paragraph "20".

NINTH: Deny the allegations contained in paragaph "21", except admit that recommendations were made to the New York City Department of Social Services in December, 1975, regarding the status of plaintiffs Yaretsky and Cuevas at American Nursing Home, but refer to the

full text of said recommendations for a true and accurate statement of the contents thereof, and refer to the appropriate published statutes and regulations for an accurate statement of the relationship between the defendants and the New York City Department of Social Services.

TENTH: Deny knowledge or information to form a belief as to the truth or accuracy of the statement contained in paragraph "22", except admit that fair hearings were held for Yaretsky and Cuevas on February 27, 1976.

ELEVENTH: Deny the allegations contained in paragraph "23", except admit that fair hearing decisions were rendered on March 30, 1976 and refer this court to the full text of the fair hearing decision for a true and accurate statement of the contents thereof.

TWELFTH: Deny the allegations contained in paragraph "24", except admit that plaintiffs Yaretsky and Cuevas, by letter dated June 14, 1976, requested an official of New York State Department of Social Services to set aside the decisions and schedule new hearings, and admit that by letter dated July 23, 1976, said official denied this request.

THIRTEENTH: Deny knowledge or information sufficient to form a belief as to the truth or accuracy of the statements contained in paragraph "26".

FOURTEENTH: Deny each and every allegation contained in paragraphs "2", "6", "7", "10", "11", "17", "18", "25", "27", "28", "29", "30", "31", "32", "33", "34", "35 (a-g)", "36", "37", "38", "39 (a-c)", "40", "41", "42", "43", "44", "45", "46", "47", "48 (a-c)" and "49".

AS AND FOR A FIRST COMPLETE AND AFFIRMATIVE DEFENSE.

FIFTEENTH: This Court has no subject matter jurisdiction.

AS AND FOR A SECOND COMPLETE AND AFFIRMATIVE DEFENSE.

SIXTEENTH: This Court should abstain from this action.

AS AND FOR A THIRD COMPLETE AND AFFIRMATIVE DEFENSE.

SEVENTEENTH: This action is barred by the doctrines of waiver and estoppel.

AS AND FOR A FOURTH COMPLETE AND AFFIRMATIVE DEFENSE.

EIGHTEENTH: Defendants have violated no constitutional or statutory or other rights of the plaintiffs.

AS AND FOR A FIFTH COMPLETE AND AFFIRMATIVE DEFENSE.

NINETEENTH: The complaint fails to state a claim upon which relief can be granted.

AS AND FOR A SIXTH COMPLETE AND AFFIRMATIVE DEFENSE.

TWENTIETH: Class action status is inappropriate for this action and should be denied.

AS AND FOR A SEVENTH COMPLETE AND AFFIRMATIVE DEFENSE.

TWENTY-FIRST: Damages against the defendants are barred by the Eleventh Amendment to the United States Constitution.

AS AND FOR A EIGHTH COMPLETE AND AFFIRMATIVE DEFENSE.

TWENTY-SECOND: Defendants at all times relevant herein acted in good faith in all respects.

AS AND FOR A NINTH COMPLETE AND AFFIRMATIVE DEFENSE.

TWENTY-THIRD: The complaint fails to set forth facts sufficient for showing the violation of any constitutional right or other basis of federal jurisdiction.

WHEREFORE, defendants Toia and Whalen respectfully request that the complaint be dismissed in all respects, that defendants be awarded costs and disbursements of this action, and such other and further relief as the Court deems just and proper.

Dated: New York, New York
May 23, 1977

LOUIS J. LEFKOWITZ
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Attorney for Defendants Toia and Whalen

By s/ KEVIN MCKAY
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November 30, 1977 Order to Show Cause Joining Plaintiffs-Intervenors Wolper, Shulman, Rossoff and Ashkenazy and Issuing Temporary Restraining Order

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

CIVIL ACTION
No. 76 Civ. 3360
(CBM)

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTERS, NEW YORK CHAPTER,

Plaintiffs,

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, and PAULINE ASHKENAZY, on behalf of themselves, and all others similarly situated,

against

CARMEN SHANG, individually and as acting Commissioner of the New York State Department of Social Services; ROBERT P. WHALEN, M.D., individually and as Commissioner of the New York State Department of Health; and J. HENRY SMITH, individually and as Commissioner of the New York City Department of Social Services,

Defendants.

Upon the attached proposed intervenor complaint, attached affidavits, plaintiff-intervenor's supporting brief dated November 22, 1977, and all prior papers and proceedings in this action, it is

November 30, 1977 Order to Show Cause—Wolper, Shulman, Rossoff, Ashkenazy

ORDERED, that the defendants or their attorneys show cause before this Court in Room 905 in the United States Court House, Foley Square, New York, New York on the 8th day of December, 1977, at 10 o'clock in the forenoon of that day, or as soon thereafter as counsel may be heard, WHY an order should not be made granting, pending the determination of this action, a preliminary injunction, pursuant to Rule 65 of the Federal Rules of Civil Procedure, enjoining and restraining the defendants, and their successors in office, officers, servants, employees and agents, including the proprietor and manager of the Parkshore Manor health related facility, from discontinuing the eligibility of the plaintiffs-intervenors Rae Wolper, Rose Shulman, Bessie Rossoff, and Pauline Ashkenazy to remain in the health related facility in which they are patients, from failing to continue uninterrupted their full levels of Medical Assistance (Medicaid) benefits for intermediate nursing care, and from transfering said plaintiffs-intervenors from the Parkshore Manor health related facility.

ORDERED, that pursuant to Rules 24(b)(2) of the Federal Rules of Civil Procedures, Rae Wolper, Rose Shulman, Bessie Rossoff, and Pauline Ashkenazy be and hereby are permitted to intervene as plaintiffs in the above-entitled action.

ORDERED, that pursuant to Rule 21 of the Federal Rules of Civil Procedure, J. Henry Smith, individually and as Commissioner of the New York City Department of Social Services, be and hereby is joined as a party defendant in this action.

ORDERED, pursuant to Rule 65 of the Federal Rules of Civil Procedure, that pending the final determination by

this Court of the plaintiffs-intervenors' motion for a preliminary injunction, the defendants and their sucessors in office, servants, employees and agents, including the proprietor and manager of the Parkshore Manor health related facility, be and the same hereby are temporarily enjoined and restrained from discontinuing the eligibility of the plaintiffs-intervenors Rae Wolper, Rose Shulman, Bessie Rossoff, and Pauline Ashkenazy to remain in the health related facility in which they are patients from failing to continue uninterrupted their full levels of Medical Assistance (Medicaid) benefits for intermediate nursing care, and from transfering said plaintiffs-intervenors from the Parkshore Manor health related facility. Security for this application pursuant to Rule 65 is waived because of the poverty of the plaintiffs-intervenors.

Sufficient reason appearing therefore, it is FURTHER ORDERED, that personal service of a copy of this order and the papers upon which it was granted, on the Attorney General of the State of New York, Two World Trade Center, New York, New York, and on the Corporation Counsel of the City of New York, Municipal Building, New York, New York, on or before 6 o'clock pm on the 30 day of November 1977, shall constitute sufficient service of this order.

Dated: New York, New York
November 30, 1977.

s/ CONSTANCE BAKER MOTLEY
UNITED STATES DISTRICT JUDGE

December 13, 1977 Order to Show Cause Joining Plaintiffs-Intervenors Birenzweig, Zahl, Kolman, J. Lundy and P. Lundy, Certifying Class and Issuing Temporary Restraining Order for All Intervenors

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

CIVIL ACTION
No. 76 Civ. 3360
(CBM)

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTERS, NEW YORK CHAPTER,

Plaintiffs,

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY, and PHILOMENA LATONE LUNDY, on behalf of themselves and all others similarly situated,

Plaintiffs-Intervenors,

against

CARMEN SHANG, individually and as acting Commissioner of the New York State Department of Social Services; ROBERT WHALEN, M.D., individually and as Commissioner of the New York State Department of Health; and J. HENRY SMITH, individually and as Commissioner of the New York City Department of Social Services,

Defendants.

December 13, 1977 Order to Show Cause (Birenzweig, Zahl, Kolman, J. Lundy, P. Lundy)—Class Certification—Temporary Restraining Order

Upon the proposed intervenor complaint, supporting affidavits, plaintiffs-intervenors' supporting brief, and all prior proceedings and papers in this action, it is

ORDERED, that the defendants or their attorneys show cause before this Court in Room 905 in the United States Court House, Foley Square, New York, New York, on the 20th day of December, 1977, at 2:00 p.m. in the afternoon of that day, or as soon thereafter as counsel can be heard, WHY an order should not be made, granting, pending the determination of this action, a preliminary injunction, pursuant to Rule 65 of the Federal Rules of Civil Procedure, enjoining and restraining the defendants, and their successors in office, officers, servants, employees and agents, including the proprietors and managers of skilled nursing and intermediate care facilities in New York State, from discontinuing the eligibility to remain in the facilities in which they reside, from transfering from the facilities, and from reducing and terminating the Medicaid benefits of plaintiffs-intervenors Mary Foley, Rae Wolper, Rose Shulman, Pauline Ashkenazy, Sadie Birenzweig, Martha Zahl, Edna Kolman, James Lundy, Philomena Latone Lundy, and any member of the plaintiff class as defined above [below] who receives or received determination of ineligibility to remain in the skilled nursing or intermediate care facility in which he/she resides and who does not or did not receive, following determination by the Utilization Review Committee, timely and fully adequate written notice that includes a statement of what action the agency intends to take, the reasons for the intended agency action, the specific regulations supporting the action, explanation of the individual's right to request an evidentiary state agency hearing, and the circumstances under which assistance is continued if a hearing is re-

quested, and/or does not or did not have prior to the fair hearing notice of access and a fully adequate opportunity to examine the contents of his/her files and records and all documents and records used against him/her at the hearing or relied on in making the initial determination, including medical records.

ORDERED (1), that pursuant to Rule 24(b)(2) of the Federal Rules of Civil Procedure, Sadie Birenzweig, Martha Zahl, Edna Kolman, James Lundy and Philomena Latone Lundy be and hereby are permitted to intervene as plaintiffs in the above-entitled action;

ORDERED (2), pursuant to Rule 23(c)(1) of the Federal Rules of Civil Procedure, that this action is to be maintained as a class action pursuant to Rule 23(a) and Rule 23(b)(2) of the Federal Rules of Civil Procedure, the class to be defined as all persons who are residents in skilled nursing or intermediate care facilities in the State of New York and who, following utilization review recommendations and/or fair hearings, are determined by defendants to be ineligible to receive the level of care at the facilities in which they reside and to be subject to reduction or termination of their Medicaid benefits; and

ORDERED (3), pursuant to Rule 65 of the Federal Rules of Civil Procedure, that pending the final determination by this Court of the plaintiffs-intervenors' motion for a preliminary injunction, the defendants and their successors in office, servants, employees and agents, including the proprietors and managers of the respective skilled nursing and health related facilities, be and the same hereby are temporarily enjoined and restrained from discontinuing the eligibility of the plaintiffs-intervenors

December 13, 1977 Order to Show Cause (Birenzweig, Zahl, Kolman, J. Lundy, P. Lundy)—Class Certification—Temporary Restraining Order

Mary Foley, Rae Wolper, Rose Shulman, Pauline Ashkenazy, Martha Zahl, Sadie Birenzweig, Edna Kolman, James Lundy and Philomena Latona Lundy to remain in the skilled nursing or intermediate care facilities in which they are patients, from failing to continue uninterrupted their full levels of Medical Assistance (Medicaid) benefits for skilled nursing or intermediate nursing care, and from transfering said plaintiffs-intervenors from the facilities in which they now reside. Security for this application pursuant to Rule 65 is waived because of the poverty of the plaintiffs-intervenors.

Sufficient reason appearing therefore, it is FURTHER ORDERED, that personal service of a copy of this order and the papers upon which it was granted, on the Attorney General of the State of New York, Two World Trade Center, New York, New York, and on the Corporation Counsel of the City of New York, Municipal Building, New York, New York, on or before 5 o'clock p.m. on the 14th day of December 1977, shall constitute sufficient service of this order.

Dated: New York, New York
December 13, 1977.

/s/ CONSTANCE BAKER MOTLEY
UNITED STATES DISTRICT JUDGE

Intervenor Complaint—Foley (Excerpts)

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

Civil Action No. 76 Civ. 3360 (CBM)
INTERVENOR COMPLAINT—CLASS ACTION

MARY FOLEY, on behalf of herself and all others similarly situated,

Plaintiffs,

against

CARMEN SHANG, individually and as Acting Commissioner of the New York State Department of Social Services; and ROBERT P. WHALEN, M.D., individually and as Commissioner of the New York State Department of Health,

Defendants.

PRELIMINARY STATEMENT

* * *

2. By this action, the named plaintiff, on behalf of herself and all others similarly situated, seeks a judgment declaring invalid as violative of the Social Security Act, applicable federal regulations, and the Due Process and Equal Protection Clauses of the Fourteenth Amendment defendants' policies and practices, on their face and as applied, with respect to the utilization review and fair hearing procedures for determining a patient's eligibility to remain in his/her skilled nursing facility and to continue to receive full Medical Assistance ("Medicaid") benefits for skilled nursing service.

3. By this action, the named plaintiff, on behalf of herself and all others similarly situated, seeks a preliminary and permanent injunction enjoining and restraining the defendants their successors, and their agents from determining any patient ineligible to remain in his/her skilled nursing facility, and from reducing or terminating the patient's Medicaid benefits, without full compliance with all applicable requirements of the Social Security Act, federal regulations, and the Due Process and Equal Protection Clauses of the Fourteenth Amendment.

* * *

CLASS ACTION ALLEGATIONS

9. Plaintiff brings this action as a class action pursuant to Rule 23(a), and in addition Rule 23(b)(2) or in the alternative Rule 23(b)(1)(A) or (B) of the Federal Rules of Civil Procedure.

10. The plaintiff class is composed of all persons who are patients in skilled nursing facilities in the State of New York and receive Medicaid assistance for skilled nursing services, and who are determined by defendants to be ineligible to remain in their skilled nursing facilities and subject to the reduction or termination of their Medicaid payments.

11. This class action is properly brought pursuant to Rule 23 because (a) the class, numbering in the hundreds, is so numerous that joinder of all members is impracticable; (b) there are questions of law and fact common to the class, namely, whether the utilization review and fair hearing procedures that result in the determination that the plaintiff and plaintiff class members are ineligible to remain in their skilled nursing facilities and to receive Medicaid assistance for skilled nursing services violate

the Social Security Act, applicable federal regulations, and the Due Process and Equal Protection Clauses of the Fourteenth Amendment; (c) the claims of the representative plaintiff are typical of the claims of the members of the class; (d) the plaintiff's attorneys have legal resources and experience adequate to protect all members of the class, and the plaintiff will fairly and adequately protect the interests of the class; (e) the defendants, in determining plaintiff and plaintiff class members ineligible to remain in their skilled nursing facilities and to continue to receive full Medicaid assistance for skilled nursing services, by way of utilization review and fair hearing procedures that are invalid under federal law and the Constitution, have acted and refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief and corresponding declaratory relief with respect to the class as a whole; and (f) the prosecution of separate actions by individual members of the class would create a risk of varying adjudications with respect to individual members of the class which might establish incompatible standards of conduct for the defendants in this action, and would create a risk of adjudications with respect to individual members of the class that would as a practical matter be dispositive of the interests of the other members not parties to the adjudications or substantially impair or impede their ability to protect their interests.

PLAINTIFF MARY FOLEY

12. Plaintiff Mary Foley is 71 years of age and has been a resident of Crown Nursing Home, a skilled nursing facility at 3457 Nostrand Avenue, Brooklyn, New York, since March 18, 1973.

13. Plaintiff suffers from cerebral arteriosclerosis with cerebral thrombosis, arteriosclerotic heart disease with atrial fibrillation, diabetes-obesity, and an enlarged heart; she is at times confused and depressed. She has right sided hemiparesis, dragging her right leg on ambulation, and has some weakness in her right arm. She has no sense of time and has both recent and past memory deficits.

14. Plaintiff requires constant supervision in her eating habits and counselling in order to lose weight, to improve her diabetic condition, and to aid her heart condition. She is on a diabetic low-salt diet. She requires assistance in bathing and dressing. She also receives the following medication: B complex, digoxin, Lassix, Tylenol, Dyrenium. She cannot be trusted to remember to take these medications on her own. She requires observation for edema and symptoms of hypoglycemis and acidosis.

15. Plaintiff requires skilled nursing supervision every day of the week.

16. Plaintiff pays $186.50 per month from her monthly Social Security check towards her nursing home care (leaving her a personal allowance of $28.50). All other nursing home costs are paid for by Medicaid assistance payments.

17. On or about April 20, 1977, Mrs. Thomas Earls, plaintiff's sister, received written notice that the Utilization Review Committee of Crown Nursing Home had found Ms. Foley "not in need of skilled nursing care" and recommended her to a "Health Related Facility," which provides a lower level of care. (Notice attached hereto as Exhibit 1).

18. On or about April 27, 1977, Miss Shiela Earls, plaintiff's niece, wrote to the State Department of Social Services, Fair Hearing Section, and requested a fair hearing to contest the utilization review finding.

19. Neither plaintiff nor her representative Miss Earls received any documents or notice of access to documents prior to the fair hearing.

20. A Hearing was held on October 7, 1977 at the nursing home before Bernard Rostanski, Hearing Officer. At the hearing, the City Department of Social Services introduced form DMS-1, dated 4/13/77, used by the Utilization Review Committee in making its finding in Ms. Foley's case. (Form attached hereto as Exhibit 2). No evidence of a determination by the City Department of Social Services was presented. No other evidence to show that plaintiff did not need skilled nursing care was presented.

21. Upon information and belief, the Utilization Review Committee, in making the adverse determination on the DMS-1 form, had looked only at patient's medical records and never saw or spoke to plaintiff. Upon information and belief, plaintiff's own physician, Dr. Jayamanue, had been informed of the Utilization Review recommendation, but had not signed or approved it.

22. The DMS-1 form introduced at the fair hearing to sustain the determination that Ms. Foley no longer needed skilled nursing care does not support the recommendation of the Utilization Review Committee of "Placement HRF."

23. At the fair hearing, plaintiff, by her representative Miss Earls, presented evidence of her medical condition

as stated in paragraphs 13-14, *supra*. She further introduced medical records, including nurses reports, progress notes, podiatrists notes, laboratory tests, social workers' statements and dietary notes showing plaintiff's medical condition and her continuing need for skilled nursing care. Plaintiff further showed that the trauma of transfer to a different facility would be detrimental to her health and life.

24. Mrs. Baker, a registered nurse at the home, testified at the hearing that plaintiff needed skilled nursing care and confirmed all of plaintiff's medical evidence.

25. The Hearing Officer stated at the hearing that there was no evidence of an improved condition and he would not recommend that plaintiff be moved at this time.

26. At the hearing, plaintiff's representative asked to see previous DMS-1s in the record in order to show no improvement in plaintiff's condition. Her request was denied.

27. On or about November 2, 1977, plaintiff received a Decision After Fair Hearing dated October 31, 1977 and signed by Carmen Shang, Acting Commissioner of, and Peter Mullany, Assistant Counsel to, the New York State Department of Social Services. (Decision attached hereto as Exhibit 3). That Decision affirmed the determination of plaintiff's ineligibility to remain at the skilled nursing facility. On its face, that Decision indicates that consideration was given only to the finding of the Utilization Review Committee and to only that portion of plaintiff's evidence which indicated that she needed nursing home supervision to keep from breaking her diet.

28. Neither the Hearing Officer nor the Decision of the Commissioner considered all of the medical evidence. Neither the Hearing Officer nor the Decision of the Comissioner stated the standard by which the Utilization Review Committee recommendation is reviewed. The Decision of the Commissioner simply adopted the finding of the Utilization Review Committee.

29. Plaintiff is in immediate danger of being transferred out of the skilled nursing facility in which she now resides.

30. Because of the adverse determination of the Utilization Review Committee and the Commissioner, and the resulting threat of transfer out of the skilled nursing facility in which she resides, the plaintiff Ms. Foley has suffered and continues to suffer extreme mental and emotional distress and great hardship, humiliation and trauma.

DEFENDANTS

31. Defendant Carmen Shang is the Acting Commissioner of the New York State Department of Social Services, and in that capacity he is responsible for the administration of the entire Public Assistance Program, including the Medical Assistance ("Medicaid") program, in the State of New York. He has an office at Two World Trade Center, New York, New York.

* * *

Dated: New York, New York
November 22, 1977.

Yours & etc.

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Attorneys for Plaintiffs

Inervenor Complaint—Wolper, Shulman, Rossoff, Ashkenazy (Excerpts)

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

CIVIL ACTION
No. 76 Civ. 3360
(CBM)

RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, and PAULINE ASHKENAZY,

Plaintiffs-Intervenors,

against

CARMEN SHANG, individually and as Acting Commissioner of the New York State Department of Social Services; ROBERT P. WHALEN, M.D., individually and as Commissioner of the New York State Department of Health; and J. HENRY SMITH, individually and as Commissioner of the New York City Department of Social Services,

Defendants.

PRELIMINARY STATEMENT

* * *

2. By this action, the named plaintiffs, on behalf of themselves and all others similarly situated, seek a judgment declaring invalid as violative of the Social Security Act, applicable federal regulations, and the Due Process and Equal Protection Clauses of the Fourteenth Amendment defendants' policies and practices, on their face and as applied, with respect to the utilization review and fair

hearing procedures for determining a patient's eligibility to remain in his/her intermediate care facility (denominated health-related facility in New York Law) and to continue to receive full Medical Assistance ("Medicaid") benefits for intermediate care.

3. By this action, the named plaintiffs, on behalf of themselves and all others similarly situated, seek a preliminary and permanent injunction enjoining and restraining the defendants, their successors, and their agents from determining any patient ineligible to remain in his/her intermediate care facility, and from reducing or terminating the patient's Medicaid benefits, without full compliance with all applicable requirements of the Social Security Act, federal regulations, and the Due Process and Equal Protection Clauses of the Fourteenth Amendment.

* * *

CLASS ACTION ALLEGATIONS

9. Plaintiffs bring this action as a class action pursuant to Rule 23(a), and in addition Rule 23(b)(2) or in the alternative Rule 23(b)(1)(A) or (B) of the Federal Rules of Civil Procedure.

10. The plaintiff class is composed of all persons who are patients in intermediate care facilities in the State of New York and receive Medicaid assistance for these services, and who are determined by defendants to be ineligible to remain in their facilities and subject to the reduction or termination of their Medicaid payments.

11. This class action is properly brought pursuant to Rule 23 because (a) the class, numbering in the hundreds, is so numerous that joinder of all members is impossible;

(b) there are questions of law and fact common to the class, namely, whether the utilization review and fair hearing procedures that result in the determination that the plaintiffs and plaintiff class members are ineligible to remain in their intermediate care facilities and to receive Medicaid assistance for these services violate the Social Security Act, applicable federal regulations, and the Due Process and Equal Protection Clauses of the Fourteenth Amendment; (c) the claims of the representative plaintiffs are typical of the claims of the members of the class; (d) the plaintiffs' attorneys have legal resources and experience adequate to protect all members of the class, and the plaintiffs will fairly and adequately protect the interests of the class; (e) the defendants, in determining plaintiffs and plaintiff class members ineligible to remain in their intermediate care facilities and to continue to receive full Medicaid assistance for these services, by way of utilization review and fair hearing procedures that are invalid under federal law and the Constitution, have acted and refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief and corresponding declaratory relief with respect to the class as a whole; and (f) the prosecution of separate actions by individual members of the class would create a risk of varying adjudications with respect to individual members of the class which might establish incompatible standards of conduct for the defendants in this action, and would create a risk of adjudications with respect to individual members of the class that would as a practical matter be dispositive of the interests of the other members not parties to the adjudications or substantially impair or impede their ability to protect their interests.

Intervenor Complaint—Wolper, Shulman, Rossoff, Ashkenazy

PLAINTIFFS

PLAINTIFF WOLPER

12. Plaintiff Rae Wolper is 72 years of age and has been a resident of Parkshore Manor, a Health Related Facility at 1555 Rockaway Parkway, Brooklyn, New York, since February 17, 1976.

13. Plaintiff suffers from hypertension, enlarged heart, occasional angina, arthritis and poor hearing. At times she is confused and forgetful.

14. Plaintiff requires constant supervision in taking medication and in maintaining a low salt diet. Plaintiff's electrolyte levels require periodic monitoring as does her heart condition. Her blood pressure is checked every other day and weight is checked weekly. She receives physical therapy twice per week for her arthritic knees. She also receives the following medication: Lasix, aldomet, and potassium hydrochloride (KCL). Supervision is required in administering these medications since plaintiff does not always remember to take them.

15. Plaintiff requires nursing and therapeutic care every day of the week.

16. Plaintiff pays $157.50 per month from her monthly Social Security check towards her health care (leaving her a personal allowance of $28.50). All other health care costs are paid for by Medical Assistance payments (Medicaid).

17. On or about June 25, 1977, Miss Barbara Nathanson, a social worker at Parkshore Manor, verbally informed plaintiff that she was recommended for transfer and that

she could request a fair hearing. No written notice was received.

18. On or about July 6, 1977, Miss Barbara Nathanson requested a fair hearing for the plaintiff from the State Department of Social Services, Fair Hearing Section.

19. Neither plaintiff nor her representative received any documents or notice of access to documents prior to the fair hearing except for the DMS-1.

20. A hearing was held on October 24, 1977 at the Health Related Facility before Bernard Rostanski, Hearing Officer. At the hearing, the City Department of Social Services was not present. Form DMS-1 was introduced as evidence. No evidence of a determination by the City Department of Social Services was presented. No other evidence to show that plaintiff did not need nursing and other health related care was presented.

21. Upon information and belief, the Utilization Review Committee, in making the determination on the DMS-1, had looked only at patient's medical records and never saw or spoke to plaintiff. Upon information and belief, plaintiff's physician, Dr. Zodiatis, had been informed of the Utilization Review recommendation, and appealed the decision, presenting his case for disapproval.

22. The DMS-1 form introduced at the fair hearing to sustain the determination on its face and in particular on question 9 a, b, and c does not support the recommendation of the Utilization Review Committee of "Transfer to HFA" (Adult Home).

23. At the fair hearing, plaintiff, by her representative, Bea Oaks, presented evidence of her medical condition as

stated in paragraphs 13-14, *supra*. She further testified that the trauma of transfer to a different facility would be detrimental to her health and life.

24. Shahed Ahmed, M.D., plaintiff's private doctor, wrote a letter which was presented at the hearing, recommending that the present level of health care be maintained since it is needed to control her medical conditions.

25. The representative at the hearing asked to see previous DMS-1s as well as the medical record to show no change in plaintiff's condition. Her request was denied.

26. On or about November 19, 1977, plaintiff received a Decision After Fair Hearing dated November 17, 1977, and signed by Carmen Shang, Acting Commissioner, and Peter Mullany, Assistant Counsel to the New York State Department of Social Services. That Decision affirmed the determination of plaintiff's ineligibility to remain at the Health Related facility. On its face, that Decision indicates that consideration was given only to the finding of the Utilization Review Committee and states merely that Plaintiff failed to present sufficient medical evidence.

27. Neither the Hearing Officer nor the decision of the Commissioner considered all of the medical evidence. Neither the hearing officer nor the Decision of the Commissioner stated the standard by which the Utilization Review Committee recommendation is reviewed. The Decision of the Commissioner simply adopted the findings of the Utilization Review Committee.

28. Plaintiff is in immediate danger of being transferred out of the health related facility in which she now resides. The Adult Home to which she will be transferred receives

no Medicaid Reimbursement and as a matter of law can provide no nursing or other health related care.

29. Because of the adverse determination of the Utilization Review Committee and the Commissioner, and the resulting threat of transfer out of the health related facility in which she resides, the plaintiff, Ms. Wolper has suffered and continues to suffer extreme mental and emotional distress and great hardship, humiliation and trauma.

PLAINTIFF SHULMAN

30. Plaintiff Rose Shulman is 75 years of age and since March 20, 1975 has been a resident of Parkshore Manor, a Health Related Facility located at 1555 Rockaway Parkway, Brooklyn, New York.

31. Plaintiff suffers from diabetes mellitus, dropped bladder, peptic ulcer, cysticele syricope, and heart problems and has heart pain, shortness of breath, dizziness and fainting spells. Last year plaintiff had a heart attack which kept her in the hospital for thirteen days. She had a spinal operation seven years ago and also cannot see well with her right eye.

32. Plaintiff requires supervision in her eating habits and to deal with her heart condition. She is on a diabetic low salt diet. She also receives various medication, including digoxin, diabenese, lasix, pencogasic, vasodilian, valium and tylenol. Plaintiff cannot always remember to take these medications on her own.

33. Plaintiff requires observation to have her urine checked daily, to have regular blood tests, and have her blood pressure monitored. She also requires observation because of her dizzy spells; she has fallen twice in the past

several weeks and had to be helped to her room. She requires health related facility care every day of the week.

34. Plaintiff pays $136.50 per month from her monthly Social Security check toward her health related care (leaving her a personal allowance of $28.50). All other health related care costs are paid for by Medicaid benefits.

35. On or about July 29, 1977 a Utilization Review Committee recommendation was made that plaintiff be transferred out of the Health Related Facility in which she resides to an adult home (HFA). An adult home receives no Medicaid reimbursement benefits and as a matter of law can provide no nursing or other health related care. Plaintiff was verbally informed of this recommendation to transfer her. She received no written notice.

36. Upon information and belief, the Utilization Review Committee, in making the transfer recommendation, looked only at plaintiff's medical records and never saw or spoke to her. Her physician, Dr. Zodiatis, did not approve the Utilization Review recommendation. According to the DMS-1 form on which the Utilization Review recommendation was made, the doctor's appeal was overturned because plaintiff supposedly did not have any fainting spells for over one year; that is not true (see above).

37. Plaintiff's daughter Gertrude Resnick requested a fair hearing to review the transfer recommendation of the Utilization Review Committee.

38. Prior to the fair hearing neither plaintiff nor her representative received any notice, written or oral, of

the specific criteria and reasons for the transfer determination other than the DMS-1 form, and neither plaintiff nor her representative received or was given any opportunity to examine the contents of her case file or any documents or records, other than the DMS-1, which were relevant to the issues at the hearing.

39. A fair hearing was held on October 25, 1977 at the health related facility before Bernard Rostanski, Hearing Officer. No representative from the City Department of Social Services was present. The only evidence introduced to show that plaintiff did not continue to need health related facility care was the DMS-1 form. The recommendation contained on the DMS-1 was defective (see paragraph 36, above) and plaintiff's representative, Miss Oaks, challenged it as not complying with federal regulations and standards. In addition, on its face the DMS-1 supports plaintiff's continuing need for health related facility care and the impropriety of transfer, since the registered nurse who answered questions 8 and 9 indicated that "the written orders of the attending physician and plan of care document that the [current level of] nursing and therapy are necessary," that plaintiff should not "be considered for another level of care," that "as a practical matter" she could not "be cared for as an outpatient" and that "as a practical matter" she could not "be cared for under home care."

40. Plaintiff's representative further presented evidences of her medical condition and her continuing need for health related facility care, as set forth above. Her daughter Gertrude Resnick and a friend Lily Morris also testified and confirmed plaintiff's condition. Plaintiff had earlier been transferred to the facility in which she now resides in order to be close to her daughter. Her repre-

sentative also argued that the recommended transfer should not be made because of "transfer trauma," the probable harm to plaintiff's physical and mental health caused by transfer.

41. At the hearing plaintiff's representative also asked to see her medical records; the request was denied. On information and belief, plaintiff's doctor had written in those records that she should not be transferred.

42. In mid-November, 1977 plaintiff received a "Decision after Fair Hearing" signed by defendant Carmen Shang and dated November 17, 1977, which affirmed the determination of the City Department of Social Services, found her ineligible to remain in the health related facility, and directed that she be transferred to an adult home. As is apparent on the face of the fair hearing decision, the Commissioner of Social Services simply adopted the erroneous Utilization Review determination and disregarded all the evidence presented on plaintiff's behalf at the hearing demonstrating that she continues to require health related facility care.

43. In rendering the fair hearing decision, the Commissioner failed to establish, apply and set forth criteria and safeguards to assure that the determination was made in a manner consistent with plaintiff's best interests and her total medical and psychosocial needs.

44. As a result of the adverse determination of the Commissioner, plaintiff has been found ineligible to remain in the health related facility in which she is a patient and whose servces she requires, and she will lose her Medicaid benefits for such services. The proprietor of the facility in which plaintiff resides plans on December 1, 1977 to

transfer plaintiff to an adult home where she will receive no nursing or other health related care.

45. Because of the actions of the defendants and the threat of transfer plaintiff has suffered and continues to suffer extreme mental and emotional distress and great hardship and humiliation, all of which causes her physical and mental health to further deteriorate.

PLAINTIFF ROSSOFF

46. Plaintiff Bessie Rossoff is 77 years of age and has been a resident of Parkshore Manor, a Health Related Facility at 1555 Rockaway Parkway, Brooklyn, New York since December 23, 1974. She lives there with her husband David Rossoff who is also in need of Health Related Care.

47. Plaintiff suffers from angina pectora, coronary insufficiency, hypertension, numbness of the left arm from fingers to elbow, and anxiety. She has had heart attacks in the past which have confined her to bed for a number of days.

48. Plaintiff requires constant supervision in administering her medication, maintaining a special low sodium diet, and to aid her heart condition. She requires assistance in bathing and dressing. She also receives four different medications, one of which is Valium. Plaintiff doesn't always know which medication she is supposed to take and at what particular time of day.

49. Plaintiff requires observation and monitoring of her blood pressure, periodic electrocardiogram testing and electrolyte testing.

50. Plaintiff requires nursing and other health related supervision every day of the week.

51. Plaintiff pays Parkshore Manor towards her health care from her monthly Social Security check (leaving her a personal allowance of $28.50). All other health facility costs are paid for by Medicaid.

52. Plaintiff never received any written notice that the Utilization Review Committee (URC) had recommended that she be transferred to an adult home, nor did her representative.

53. On or about May 23, 1977 plaintiff's son Edward Rossoff was given verbal notice of the URC's recommendation and on June 3, 1977 he requested a fair hearing for her.

54. Neither plaintiff nor her representative received any documents or notice of access to documents prior to the fair hearing, except for the DMS-1 Form.

55. A hearing was held on October 24, 1977 before Bernard Rostanski, State Department of Social Services Hearing Officer, at the Park Shore Manor. No representative from the City Dep't. of Social Services was present. The DMS-1 was introduced as evidence. No evidence of a determination by the City Dep't. of Social Services was presented. No other evidence to show that plaintiff did not need nursing and other health related care was presented.

56. On information and belief the URC in making the determination on the DMS-1 form had looked only at plaintiff's medical records and never saw or spoke to her. On information and belief, plaintiff's own physician, Dr. Antoniou, believed that a transfer would not be in her best

interests and appealed the determination of the URC and did not sign the DMS-1 form.

57. The DMS-1 form introduced to sustain the determination on its face and in particular on question 8, 9.a., b., and c., does not support the recommendation of the URC of "Placement Transfer To Adult Home."

58. Plaintiff and her son, Edward Rossoff, testified at the hearing as to her medical condition as stated above.

59. Plaintiff's representative at the hearing, Bea Oaks, asked to see her medical records and previous DMS-1s to show no change in her condition. Her request was denied.

60. On or about November 20, 1977, plaintiff received a Decision After Fair Hearing dated November 18, 1977 and signed by Carmen Shang, Acting Commissioner and Peter Mullany, Assistant Counsel to the New York State Department of Social Services. That decision affirmed the determination of the agency. That decision considered only the decision of the URC.

61. Neither the Hearing Officer nor the decision of the Commissioner considered all of the medical evidence. Neither the hearing officer nor the Decision of the Commissioner stated the standard by which the Utilization Review Committee recommendation is reviewed. The Decision of the Commissioner simply adopted the finding of the URC. As to the problem of plaintiff's separation from her husband, the Decision stated that the URC should reevaluate her husband to determine if he can be transferred also.

62. Plaintiff is in immediate danger of being transferred out of the Health Related Facility in which she

now resides. Unless Medicaid payments are ordered to be continued, the Facility threatens to transfer her against her will on December 1, 1977. The Adult Home to which she will be transferred receives no Medicaid Reimbursement and as a matter of law can provide no nursing or other health related care.

63. Because of the adverse determination of the Utilization Committee and the Commissioner, and the resulting threat of transfer out of the health related facility in which plaintiff resides, she has suffered and continues to suffer extreme mental and emotional distress and great hardship, humiliation and trauma.

PLAINTIFF ASHKENAZY

64. Plaintiff Pauline Ashkenazy is 79 years of age and has been a resident of Parkshore Manor, a Health Related Facility, 1555 Rockaway Parkway, Brooklyn, New York since November 25, 1974.

65. Plaintiff suffers from a heart condition, heart palpitations, rapid pulse, high blood pressure, swollen feet, head and shoulder pains, doudenal ulcers; she is depressed at times and suffers from lack of appetite.

66. Plaintiff requires constant supervision to take the following medication: Mylonta, Probathine, Glutofal, Lafronil, Periactin Syrup, alcloctone, Digoxin, and Lasix. She is on a low salt diet. She cannot remember to take all these medications.

67. Plaintiff requires to have her pulse taken daily before the administration of digoxin.

68. Plaintiff requires nursing supervision and health related care every day of the week.

Intervenor Complaint—Wolper, Shulman, Rossoff, Ashkenazy

69. Except for a contribution from plaintiff's Social Security check, all her health care costs are paid by Medicaid.

70. On or about July or August 1977 plaintiff was verbally informed that she could no longer remain at the Health Related facility.

71. On or about August 16, 1977, the social worker for the Facility requested a fair hearing with the State Department of Social Services.

72. Neither plaintiff nor her representative received any documents or notice of access to documents prior to the fair hearing, except for a copy of the DMS-1 form.

73. A hearing was held on October 24, 1977 at the Health Related Facility before Bernard Rostanski, Hearing Officer. At the hearing, the City Department of Social Services was not present. Form DMS-1 dated July 22, 1977 was introduced in evidence. No evidence of a determination by the City Department of Social Services was presented. No other evidence to show that plaintiff did not need nursing and other health related care was presented.

74. Upon information and belief, the Utilization Review Committee, in making the determination on the DMS-1, had looked only at plaintiff's medical records and never saw or spoke to her.

75. The DMS-1 form introduced at the fair hearing to sustain the determination, on its face and in particular on questions 3E and 8 does not support the recommendation of the Utilization Review Committee of "Transfer To Adult Home."

Intervenor Complaint—Wolper, Shulman, Rossoff, Ashkenazy

76. At the fair hearing, plaintiff's representative, Bea Oaks, presented evidence of her medical condition as stated above. She further argued that the trauma of transfer to a different facility would be detrimental to plaintiff's health and life. Plaintiff testified as to her condition.

77. Plaintiff requested at the hearing through her representative to have her medical records and the prior DMS-1 forms made available. They were not made available to her.

78. On or about November 20, 1977, plaintiff received a Decision After Fair Hearing dated November 17, 1977, and signed by Carmen Shang, Acting Commissioner, and Peter Mullany, Assistant Counsel to the New York State Department of Social Services. That Decision affirmed the determination of ineligibility to remain at the Health Related Facility. On its face, that Decision indicates that consideration was given only to the finding of the Utilization Review Committee and states merely that plaintiff presented no medical evidence.

79. Neither the Hearing Officer nor the decision of the Commissioner considered all of the medical evidence. Neither the Hearing Officer nor the Decision of the Commissioner stated the standard by which the Utilization Review Committee recommendation is reviewed. The Decision of the Commissioner simply adopted the finding of the Utilization Review Committee.

80. Plaintiff is in immediate danger of being transferred out of the Health Related Facility in which she now resides. Unless Medicaid Payments are ordered to be continued, the Facility threatens to transfer her against

her will on December 1, 1977. The Adult Home to which she will be transferred receives no Medicaid Reimbursement and as a matter of law can provide no nursing or other health related care.

81. Because of the adverse determination of the Utilization Review Committee and the Commissioner, and the resulting threat of transfer out of the health related facility in which plaintiff resides, she has suffered and continues to suffer extreme mental and emotional distress and great hardship, humiliation and trauma.

82. This transfer might harm plaintiff beyond repair by worsening her medical condition and even possibly resulting in her death.

* * *

DEFENDANTS

* * *

87. Defendant J. Henry Smith is the Commissioner of the New York City Department of Social Services, and in that capacity is responsible for the administration of the Medical Assistance ("Medicaid") program in the City of New York. The New York City Department of Social Services makes a determination finding a patient ineligible for continuing care at a particular nursing facility and it is that determination which is reviewed at the State fair hearing. Defendant Smith's office is at 250 Church Street, New York, New York.

STATUTORY AND REGULATORY SCHEME

* * *

92. 42 U.S.C. § 1396b(g)(1) requires that a state have in operation an effective program of control over utilization of skilled nursing and intermediate care services.

93. Federal regulations require that the state agency administering the Medicaid program establish and implement a state-wide utilization control program including a continuous program of review of the utilization of and need for intermediate care services for which Medicaid payment is claimed. 45 C.F.R. § 250.18.

94. The requirements of the utilization review plan required of each Intermediate Care Facility are set forth in 45 C.F.R. § 250.19(a)(4).

95. In general, utilization review committees are to be established in each intermediate care home to evaluate the continued need of each patient for ICF care every 6 months. The definition of need for intermediate care is codified at 45 C.F.R. § 249.10(a)(15). Committees are made up of physicians and professionals who are not employees or financially interested in the nursing home and not directly responsible for the patients' care. 45 C.F.R. §§ 250.19(a) (4). Also 10 N.Y.C.R.R. § 741.14.

96. If the Utilization Review Committee recommends that the patient does not require intermediate care, the nursing home, attending physician, patient and next of kin are to be notified in writing of the finding. Notice is also to be given to an official under the control and direction of the state agency who is responsible for making decisions regarding the patient's Medicaid eligibility and payment. 45 C.F.R. §§ 250.19(a)(4).

• • •

98. The State is required to establish and insure compliance with standards, methods, and safeguards to assure that intermediate care services are given to those who need them and that eligibility for such services is determined in a manner consistent with the best interests of the patients. 42 U.S.C. §§ 1396a(a)(17), (a)(19), (a)(22) (D); 1396b(g)(1)(D). 45 C.F.R. § 250.24.

* * *

101. The State is required to insure that a patient is not transferred from a nursing home without consulting with the patient, and unless for medical reasons. 45 C.F.R. § 249.12.

102. The New York City Department of Social Services purportedly renders, following the Utilization Review Committee's recommendation, a determination that a patient is not eligible to continue to receive the level of care he/she is receiving at the facility where he/she resides. That determination is subject to fair hearing review by the State Department of Social Services.

* * *

Dated: New York, New York
November 30, 1977

Yours & etc.,

[Attorneys' subscriptions and office addresses omitted in printing.]

Attorneys for Plaintiffs-Intervenors

Intervenor Complaint—Birenzweig, Zahl, Kolman, J. Lundy, P. Lundy (Excerpts)

UNITED STATE DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

CIVIL ACTION
No. 76 Civ. 3360
(CBM)

INTERVENOR COMPLAINT—CLASS ACTION

SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY, and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Plaintiffs,

against

CARMEN SHANG, individually and as Acting Commissioner of the New York State Department of Social Services; ROBERT P. WHALEN, M.D., individually and as Commissioner of the New York State Department of Health; and J. HENRY SMITH, individually and as Commissioner of the New York City Department of Social Services,

Defendants.

PRELIMINARY STATEMENT

• • •

3. By this action, the named plaintiffs, on behalf of themselves and all others similarly situated, seek a preliminary and permanent injunction enjoining and restraining the defendants, their successors, and their agents from

determining any patient ineligible to remain in his/her skilled nursing or intermediate care facility, and from reducing or terminating the patient's Medicaid benefits, without full compliance with all applicable requirements of the Social Security Act, federal regulations, New York State Administrative Procedure Act and the Due Process and Equal Protection Clauses of the Fourteenth Amendment.

* * *

CLASS ACTION ALLEGATIONS

9. Plaintiffs bring this action as a class action pursuant to Rule 23(a), and in addition Rule 23(b)(2) or in the alternative Rule 23(b)(1)(A) or (B) of the Federal Rules of Civil Procedure.

10. The plaintiff class is composed of all persons who are patients in skilled nursing or intermediate care facilities in the State of New York and receive Medicaid assistance for these services, and who are determined by defendants to be ineligible to remain in their facilities and subject to the reduction or termination of their Medicaid payments.

11. This class action is properly brought pursuant to Rule 23 because (a) the class, numbering in the hundreds, is so numerous that joinder of all members is impossible; (b) there are questions of law and fact common to the class, namely, whether the utilization review and fair hearing procedures that result in the determination that the plaintiffs and plaintiff class members are ineligible to remain in their skilled nursing or intermediate care facilities and to receive Medicaid assistance for these services violate the Social Security Act, applicable federal regulations, New York State Administrative Procedure Act and

the Due Process and Equal Protection Clauses of the Fourteenth Amendment; (c) the claims of the representative plaintiffs are typical of the claims of the members of the class; (d) the plaintiffs' attorneys have legal resources and experience adequate to protect all members of the class, and the plaintiffs will fairly and adequately protect the interests of the class; (e) the defendants, in determining plaintiffs and plaintiff class members ineligible to remain in their skilled nursing or intermediate care facilities and to continue to receive full Medicaid assistance for these services, by way of utilization review and fair hearing procedures that are invalid under federal and state law and the Constitution, have acted and refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief and corresponding declaratory relief with respect to the class as a whole; and (f) the prosecution of separate actions by individual members of the class would create a risk of varying adjudications with respect to individual members of the class which might establish incompatible standards of conduct for the defendants in this action, and would create a risk of adjudications with respect to individual members of the class that would as a practical matter be dispositive of the interests of the other members not parties to the adjudications or substantially impair or impede their ability to protect their interests.

Plaintiffs

Plaintiff Sadie Birenzweig

12. Plaintiff Sadie Birenzweig, is 93 years of age and has been a resident of Sheepshead Nursing Home, a skilled nursing facility at 2840 Knapp Street, Brooklyn, New York for about one (1) year.

Intervenor Complaint—Birenzweig, Zahl, Kolman, J. Lundy, P. Lundy

13. Plaintiff had two strokes, has severe cataracts in her eyes, is hard of hearing, walks with a walker, has arteriosclerosis heart disease, high blood pressure, arthritis and memory deficits.

14. Plaintiff requires constant supervision in taking medication and maintaining a salt-free diet. She needs assistance in dressing and bathing.

15. Plaintiff requires observation for problems with her feet, and a chronic infection problem with her finger.

16. Plaintiff requires skilled nursing and therapeutic care every day of the week.

17. Plaintiff pays the nursing home every month from her monthly Social Security check (leaving her a personal allowance of $28.50). All other health care costs are paid for by Medical Assistance payments (Medicaid).

18. On or about July 1977 a social worker at the nursing home verbally informed plaintiff's daughter Marion Kopelowitz, that plaintiff was recommended for transfer from the home and that she could request a fair hearing. Plaintiff received no written or oral notice of any kind.

19. On or about July 27, 1977, plaintiff's daughter, requested a fair hearing from the State Department of Social Services, Fair Hearing Section.

20. Neither plaintiff nor her representative received any documents whatsoever, or notice of access to documents prior to the fair hearing.

21. A hearing was held on October 24, 1977 at the Nursing Home before Bernard Rostanski, State Hearing Officer.

On information and belief, at the hearing, the City Department of Social Services was not present. Plaintiff's son and daughter were present at the hearing. Plaintiff's son, Leon Burns, asked if plaintiff should come into the hearing room. The hearing officer said it was not necessary. Plaintiff was not present for the hearing. No evidence of a determination by the City Department of Social Services was presented. No other evidence to show that plaintiff did not need nursing and other health related care was presented.

22. The Utilization Review Committee, in making the determination on the DMS-1, had looked only at plaintiff's medical records and never saw or spoke to plaintiff.

23. At the fair hearing, plaintiff's son and daughter presented evidence of her medical condition as stated in paragraphs 13-16 *supra*. They further argued that the trauma of transfer to a different facility would be detrimental to plaintiff's health and life. They were given absolutely no information at the hearing. They did not even see the DMS-1 form upon which the decision was allegedly based. They were not shown plaintiff's medical records. They were not told the basis for the decision.

24. On or about November 21, 1977 plaintiff received a Decision After Fair Hearing dated November 17, 1977 and signed by Carmen Shang, Acting Commissioner and Peter Mullany, Assistant Counsel to the New York State Department of Social Services. That Decision affirmed the determination of plaintiff's ineligibility to remain at the skilled nursing facility. On its face, that Decision indicates that consideration was given only to the finding of the Utilizatoni Review Committee and states merely that plaintiff

presented no medical evidence. The decision states plaintiff appeared at the hearing, which is not true.

25. Neither the Hearing Officer nor the decision of the Commissioner considered all of the medical evidence. Neither the Hearing Officer nor the Decision of the Commissioner stated the standard by which the Utilization Review Committee recommendation is reviewed. The Decision of the Commissioner simply adopted the finding of the Utilization Review Committee.

26. Plaintiff is in immediate danger of being transferred out of the skilled nursing facility in which she now resides. Unless Medicaid payments are ordered to be continued, the Facility threatens to transfer her against her will very shortly. The Health Related Facility to which she will be transferred provides no skilled nursing care which she requires. That Facility is further from plaintiff's family whose visits she depends on for her mental well-being. Because of plaintiff's advanced age and condition this transfer could seriously set back her health and be detrimental to her safety and life.

27. Because of the adverse determination of the Utilization Review Committee and the Commissioner, and the resulting threat of transfer out of the skilled nursing facility in which plaintiff resides, plaintiff has suffered and continues to suffer extreme mental and emotional distress and great hardship, humiliation and trauma. This transfer might harm plaintiff beyond repair by worsening her medical condition and even possibly resulting in her death.

PLAINTIFF MARTHA ZAHL

28. Martha Zahl is 87 years of age and has been a resident of Sheepshead Nursing Home, a skilled nursing

facility at 2840 Knapp Street, Brooklyn, New York since July 28, 1972.

29. Plaintiff suffers from high blood pressure, hypertension, osteoarthritis, cerebral ischemia, osteoporotuis.

30. Plaintiff requires constant supervision in taking medication and in bathing and dressing, taking of blood pressure before Digoxin is administered, therapy for her legs, hot water pads, podiatrist supervision. Plaintiff also receives the following medication: Lasix, Digoxin, Aldomet, K-Lyte, Nitroglycerine.

31. Plaintiff requires nursing and therapeutic care every day of the week.

32. Plaintiff pays $116 per month from her monthly Social Security check towards her health care (leaving her a personal allowance of $28.50). All other health care costs are paid for by Medical Assistance payments (Medicaid).

33. On or about July 1977, written notice was sent to plaintiff's daughter, Miriam Tessler, stating that plaintiff was recommended for transfer to a Health Related Facility and that she could request a fair hearing. Plaintiff received no written notice of any kind.

34. On or about July 1977, plaintiff's son Solomon Zahl requested a fair hearing from the State Department of Social Services, Fair Hearing Section.

35. Neither plaintiff nor her representative received any documents or notice of access to documents prior to the fair hearing.

Intervenor Complaint—Birenzweig, Zahl, Kolman, J. Lundy, P. Lundy

36. A hearing was held on October 24, 1977 at the skilled nursing facility before Bernard Rostanski, State Hearing Officer. At the hearing, the City Department of Social Services was not present. Plaintiff was not shown the DMS-1 form which is claimed was introduced as evidence. No evidence of a determination by the City Department of Social Services was presented. No other evidence to show that plaintiff did not need nursing and other health related care was presented.

37. Upon information and belief, the Utilization Review Committee, in making the determination on the DMS-1, had looked only at plaintiff's medical records and never saw or spoke to plaintiff. The DMS-1 form incorrectly fails to note that: Plaintiff cannot walk without assistance (ques. 4); plaintiff uses a wheelchair; for bathing, plaintiff needs total help (ques. 4); for dressing, plaintiff needs total help (ques. 4); and plaintiff's hearing is impaired (ques. 6).

38. The DSM-1 form allegedly introduced at the fair hearing to sustain the determination on its face and in particular on question 3f, 3e and 8 does not support the recommendation of the Utilization Review Committee of "Placement HRF".

39. At the fair hearing, plaintiff's son, Solomon Zahl, did not know and was not informed he could present medical evidence at the hearing. Neither he nor plaintiff was given access to plaintiff's medical records. Neither he nor plaintiff was informed of the basis for the initial decision or the standard, if any, for reviewing it.

40. On or about November 25, 1977, plaintiff received a Decision After Fair Hearing dated October 24, 1977, and

signed by Carmen Shang, Acting Commissioner and Peter Mullany, Assistant Counsel to the New York State Department of Social Services. That Decision affirmed the determination of plaintiff's ineligibility to remain at the skilled nursing facility. On its fact, that Decision indicates that consideration was given only to the finding of the Utilization Review Committee and states merely that plaintiff presented no medical evidence.

41. Neither the Hearing Officer nor the Decision of the Commissioner considered all of the medical evidence. Neither the Hearing Officer nor the Decision of the Commissioner stated the standard by which the Utilization Review Committee recommendation is reviewed. The Decision of the Commissioner simply adopted the finding of the Utilization Review Committee.

42. Plaintiff is in immediate danger of being transferred out of the skilled nursing facility in which she now resides. Unless Medicaid payments are ordered to be continued, the Facility threatens to transfer her against her will.

43. Because of the adverse determination of the Utilization Review Committee and the Commissioner, and the resulting threat of transfer out of the skilled nursing facility in which plaintiff resides, she has suffered and continues to suffer extreme mental and emotional distress and great hardship, humiliation and trauma. This transfer might harm plaintiff beyond repair by worsening her medical condition and even possibly resulting in her death.

PLAINTIFF EDNA KOLMAN

44. Plaintiff Edna Kolman, is 87 years of age and has been a resident of Crown Nursing Home, a skilled nursing

facility at 3457 Nostrand Avenue, Brooklyn, New York, for approximately nine (9) years.

45. Plaintiff suffers from cataracts in both eyes. She is only ambulatory for a few feet from her wheelchair; she has a history of cardiac problems and is incontinent at times. Plaintiff also suffers from arterialsclerosis and has dizzy spells.

46. Plaintiff requires constant supervision in taking medication and in her special diet. She needs aid in bathing. On or about July 20, 1977 plaintiff suffered a dizzy spell while in her bathroom causing her to fall and strike her head on the tile and resulting in medical treatment.

47. Plaintiff requires nursing and therapeutic care every day of the week.

48. Plaintiff pays the nursing home every month from her monthly Social Security check towards her health care (leaving her a personal allowance of $28.50). All other health care costs are paid for by Medical Assistance payments (Medicaid).

49. On or about March 10, 1977, plaintiff's daughter, Sylvia Pizzi was informed that she was recommended for transfer and that she could request a fair hearing. Plaintiff personally received no written or oral notice of any kind.

50. On or about March 1977, plaintiff's daughter, Sylvia Pizzi, requested a fair hearing from the State Department of Social Services, Fair Hearing Section.

51. Neither plaintiff nor her representative received any documents or notice of access to documents prior to the fair hearing.

Intervenor Complaint—Birenzweig, Zahl, Kolman, J. Lundy, P. Lundy

52. A hearing was held on June 8, 1977 at the skilled nursing facility before John M. Burke, State Hearing Officer. On information and belief Form DMS-1 was introduced as evidence. No evidence of a determination by the City Department of Social Services was presented. No other evidence to show that plaintiff did not need skilled nursing and other health care was presented.

53. The Utilization Review Committee, in making the determination on the DMS-1, had looked only at plaintiff's medical records and never saw or spoke to plaintiff.

54. At the fair hearing, plaintiff's representative, Ms. Pizzi, presented evidence of her medical condition as stated in paragraphs 44-47 above. She presented at the hearing Progress Notes from previous years signed by Dr. Fletcher which stated: "After a careful review of Mrs. Kolman's records, it is my opinion that she continues to require nursing home care and not be transferred to another facility. She is a known cardiac for many years. Has . . . [unclear] . . . not able to care for self. After 6 years in this facility transfer would also be severe psychological trauma if any changes were made."

55. Plaintiff's representative asked to see her medical records at the hearing. The request was denied.

56. On or about September 19, 1977, plaintiff received a Decision After Fair Hearing dated September 13, 1977, and signed by Carmen Shang, Acting Commissioner and Peter Mullany, Assistant Counsel to the New York State Department of Social Services. That Decision affirmed the determination of plaintiff's ineligibility to remain at the skilled nursing facility. On its face, that Decision indicates that consideration was given only to the finding of the

Utilization Review Committee and states merely that plaintiff presented no medical evidence to establish her need for nursing home care.

57. Neither the Hearing Officer nor the Decision of the Commissioner considered all of the medical evidence. Neither the Hearing Officer nor the Decision of the Commissioner stated the standard by which the Utilization Review Committee recommendation is reviewed. The Decision of the Commissioner simply adopted the finding of the Utilization Review Committee.

58. Plaintiff is in immediate danger of being transferred out of the skilled nursing facility in which she now resides. Unless Medicaid payments are ordered to be continued, the Facility threatens to transfer plaintiff against her will very shortly. The Health Related Facility to which plaintiff will be transferred provides a lesser level of care and supervision and no skilled nursing care which plaintiff requires.

59. Because of the adverse determination of the Utilization Review Committee and the Commissioner, and the resulting threat of transfer out of the skilled nursing facility in which plaintiff resides, plaintiff has suffered and continues to suffer extreme mental and emotional distress and great hardship, humiliation and trauma. This transfer might harm plaintiff beyond repair by worsening her medical condition and even possibly resulting in her death.

PLAINTIFF JAMES LUNDY

60. Plaintiff James Lundy is 65 years of age and has been a resident of River Manor, a Health Related Facility at 630 East 104th Street, Brooklyn, New York since No-

vember 10, 1975. He resides there with his wife Philomena Latona Lundy.

61. Plaintiff suffers from cerebral degeneration and other ailments.

62. Plaintiff sees the psychiatrist Dr. Briskin regularly. He requires observation.

63. Plaintiff requires nursing and therapeutic care every day of the week.

64. Plaintiff pays about $131.50 per month from his monthly Social Security check towards his health care (leaving him a personal allowance of $28.50). All other health care costs are paid for by Medical Assistance payments (Medicaid).

65. On or about December 27, 1976 a letter was received by Ms. Pons, plaintiff's relative informing her that plaintiff was recommended for transfer and that he could request a fair hearing.

66. On or about April 27, 1977, Ms. Ann Zlotnick, the social worker, requested a fair hearing from the State Department of Social Services, Fair Hearing Section.

67. Neither plaintiff nor his representative received any documents or notice of access to documents prior to the fair hearing, except for the DMS-1, which plaintiff's representative obtained from the Health Related Facility.

68. A hearing was held on November 1, 1977 at the Health Related Facility before Bernard Rostanski, State Hearing Officer. At the hearing, the City Department of

Social Services was present. Form DMS-1 was introduced as evidence. No evidence of a determination by the City Department of Social Services was presented. No other evidence to show that plaintiff did not need nursing and other health related care was presented.

69. The Utilization Review Committee, in making the determination on the DMS-1, had looked only at plaintiff's medical records and never saw or spoke to plaintiff. Plaintiff's physician, Dr. Nichols, had been informed of the Utilization Review recommendation, had disagreed with the decision, and appealed the decision, presenting his case for disapproval in writing.

70. At the fair hearing, plaintiff's representative, Bea Oaks, presented evidence of plaintiff's medical condition as stated in paragraphs 61-63 above. She further argued that the trauma of transfer to a different facility would be detrimental to plaintiff's health and life. Plaintiff testified that being separated from his wife who is in the Facility and needs Health Related care would have an adverse effect on him.

71. On or about November 22, 1977, plaintiff received a Decision After Fair Hearing dated November 18, 1977, and signed by Carmen Shang, Acting Commissioner and Peter Mullany, Assistant Counsel to the New York State Department of Social Services. That Decision affirmed the determination of plaintiff's ineligibility to remain at the Health Related Facility. On its face, that Decision indicates that consideration was given only to the finding of the Utilization Review Committee and states merely that plaintiff presented no medical evidence.

72. Neither the Hearing Officer nor the Decision of the Commissioner considered all of the medical evidence nor

the effect on plaintiff of separation from his wife. Neither the Hearing Officer nor the Decision of the Commissioner stated the standard by which the Utilization Review Committee recommendation is reviewed. The Decision of the Commissioner simply adopted the finding of the Utilization Review Committee.

73. Plaintiff is in immediate danger of being transferred out of the Health Related Facility in which he now resides. Unless Medicaid payments are ordered to be continued, the Facility threatens to transfer him against his will. The Adult Home to which plaintiff will be transferred receives no Medicaid Reimbursement and as a matter of law can provide no nursing or other health related care.

74. Because of the adverse determination of the Utilization Review Committee and the Commissioner, and the resulting threat of transfer out of the Health Related Facility in which plaintiff resides he has suffered and continues to suffer extreme mental and emotional distress and great hardship, humiliation and trauma. This transfer might harm plaintiff beyond repair by worsening his medical condition and even possibly resulting in his death.

PLAINTIFF PHILOMENA LATONA LUNDY

75. Plaintiff Philomena Latona Lundy is 62 years of age and has been a resident of River Manor, a Health Related Facility at 630 East 104th Street, Brooklyn, New York since September 17, 1976. She resides there with her husband, James Lundy.

76. Plaintiff suffers from body pains and anxiety which aggravates her pains. She had a masectomy and has

resulting pain. Plaintiff has had back pain and swelling, and ear and leg pain. She has arthritis in her fingers, nervousness, loss of hearing and skin rash. She coughs and is subject to falls. Plaintiff is agitated and depressed.

77. Plaintiff requires constant supervision in taking medication. She takes valium and Tylenol. She receives regular psychiatric counselling.

78. Plaintiff requires nursing and therapeutic care every day of the week.

79. Plaintiff pays from her monthly Supplemental Security Income check towards her health care (leaving her a personal allowance of $25). All other health care costs are paid for by Medical Assistance payments (Medicaid).

80. On or about April, 1977, a social worker at River Manor verbally informed plaintiff she was recommended for transfer and that she could request a fair hearing. Plaintiff received no written notice of any kind.

81. On or about April 29, 1977, Mrs. Ann Zlotnick the social worker requested a fair hearing for plaintiff from the State Department of Social Services, Fair Hearing Section.

82. Neither plaintiff nor her representative received any documents or notice of access to documents prior to the fair heearing, except for the DMS-1, obtained by her representative from the Health Related Facility.

83. A hearing was held on November 1, 1977 at the Health Related Facility before Bernard Rostanski, State Hearing Officer. At the hearing, the City Department of

Social Services was present. Form DMS-1 was introduced as evidence. No evidence was presented. No other evidence to show that plaintiff did not need nursing and other health related care was presented.

84. Upon information and belief, the Utilization Review Committee, in making the determination on the DMS-1, had looked only at plaintiff's medical records and never saw or spoke to her. Plaintiff's physician, Dr. Nichols, had been informed of the Utilization Review recommendation, had disagreed with the decision, and appealed the decision, presenting his case for disapproval in writing.

85. At the fair hearing, plaintiff's representative Bea Oaks, presented evidence of her medical condition as stated in paragraphs 76-78 above. She further argued that the trauma of transfer to a different facility would be detrimental to plaintiff's health and life. She introduced a report from Dr. Gold stating plaintiff's psychiatric condition. The social worker Ms. Zlotnick testified on plaintiff's medical and psychological history.

86. On or about November 22, 1977, plaintiff received a Decision After Fair Hearing dated November 18, 1977 and signed by Carmen Shang, Acting Commissioner and Peter Mullany, Assistant Counsel to the New York State Department of Social Services. That Decision affirmed the determination of plaintiff's ineligibility to remain at the Health Related Facility. On its face, that Decision indicates that consideration was given only to the finding of the Utilization Review Committee and states merely that plaintiff failed to present sufficient medical evidence.

87. Neither the Hearing Officer nor the decision of the Commissioner considered all of the medical evidence.

Intervenor Complaint—Birenzweig, Zahl, Kolman, J. Lundy, P. Lundy

Neither the Hearing Officer nor the Decision of the Commissioner stated the standard by which the Utilization Review Committee recommendation is reviewed. The Decision of the Commissioner simply adopted the finding of the Utilization Review Committee.

88. Plaintiff is in immediate danger of being transferred out of the Health Related Facility in which she now resides. Unless Medicaid Payments are ordered to be continued, the Facility threatens to transfer her against her will. The Adult Home to which plaintiff will be transferred receives no Medicaid reimbursement and as a matter of law can provide no nursing or other health related care.

89. Because of the adverse determination of the Utilization Review Committee and the Commissioner, and the resulting threat of transfer out of the Health Related Facility in which she resides, plaintiff has suffered and continues to suffer extreme mental and emotional distress and great hardship, humiliation and trauma. This transfer might harm plaintiff beyond repair by worsening her medical condition and even possibly resulting in her death.

* * *

Dated: New York, New York
December 12, 1977

Yours & etc.,

[Attorneys' subscriptions and office addresses omitted in printing.]

Attorneys for Plaintiffs-Intervenors

January 4, 1978 Hearing (Excerpts)

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

76 Civil 3360

WILLIAM YARETSKY, RALPH CUEVAS and THE GRAY PANTHERS, NEW YORK CHAPTER,

Plaintiffs,

vs.

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF and PAULINE ASHKENAZY, on behalf of themselves and all others similarly situated,

Plaintiffs-Intervenors,

vs.

CARMEN SHANG, individually and as acting Commissioner of the New York State Department of Social Services; ROBERT P. WHALEN, M.D., individually and as Commissioner of the New York State Department of Health; and J. HENRY SMITH, individually and as Commissioner of the New York City Department of Social Services,

Defendants.

Before: HON. CONSTANCE BAKER MOTLEY, District Judge

New York, New York
January 4, 1978—10:15 a.m.

[Appearances omitted in printing.]

* * *

[8] The Court: All right. Are plaintiffs ready to proceed with this hearing on their motion for preliminary injunction?

Mr. Goldfarb: Yes, your Honor, plaintiffs are ready.

Your Honor, we would like to begin, before calling our witness, to introduce some evidence on the issue of the notice.

I have five notices, which I would like to have marked in evidence and shown to the other side. All of these notices have been attached to the affidavits and they are uncontroverted by any affidavit from the defendants.

The Court: These are the notices actually received by the plaintiffs and the intervenor plaintiffs?

Mr. Goldfarb: These are the notices received by relatives.

(Plaintiffs' Exhibits 1 through 5 marked for identification.)

The Court: All right. We have those exhibits now marked Plaintiffs' Exhibits 1 through 5. Is there any [9] objection?

Mr. Agree: No objection.

Mr. Goldfarb: No objection.

The Court: All right. Plaintiffs' Exhibits 1 through 5 received.

(Plaintiffs' Exhibits 1 through 5 received in evidence.)

The Court: All right.

Mr. Goldfarb: If I may, on those written notices, I would just like to say that the definition of "adequate," according to the regulations that both sides have presented, is a written notice which includes a statement of what action the agency intends to take, the reasons for the intended agency action, the specific regulation supporting such, and explanation of the individual's right to request an evidentiary hearing.

Now, none of those notices state the regulations upon which the action is based. None of them, we believe, give the reasons for the intended agency action. At the best

they say "You have been found to no longer need the level of care." That is like telling someone they are being taken off of welfare because they no longer need public assistance. That is not adequate notice.

An adequate notice should tell these people, many [10] of which appeared with only relatives or friends or alone at these hearings, that "The doctor has determined that you no longer suffer from the following conditions and that you no longer need a skilled nurse to dress your wounds and things as when you came in and therefore you can be transferred."

We don't feel that these meet the basic Federal regulations or a due process requirement.

I would also like to introduce into evidence at this time the affidavit of Rae Wolper, Rose Shulman, Bessie Rossoff and Pauline Ashkenazy, of which I have the originals from the court papers. All of these, and I can note the paragraphs, state that these people received oral notice, these four persons, and they did not receive any written notice.

The Court: Are they relatives?

Mr. Goldfarb: No. These are the actual people in the nursing homes.

The Court: Are they different from those shown by Exhibits 1 through 5?

Mr. Goldfarb: Yes. It is different in that these people were not given any kind of written notice at all. They were told orally by someone in the nursing home.

[11] Also in the affidavits it states that each of those four persons requested to see their medical record and that request was denied. These affidavits have been presented in the order to show cause to the defendants and there is no affidavit or any information contradicting this in evi-

dence at all or presented by either the State or City defendant.

The Court: All right. Are they all together in one document?

Mr. Goldfarb: Yes.

The Court: Let's have it marked as Plaintiffs' Exhibit 6.

(Plaintiffs' Exhibit 6 marked for identification.)

The Court: Any objection to Plaintiffs' Exhibit 6?

Mr. McKay: Yes, your Honor. We would object to the admission of those affidavits because they contain several allegations concerning not only the notice but the discovery they were permitted or not permitted, as the case may be, and there are several issues raised there which are extremely difficult to verify without cross-examining the persons themselves. So on those grounds I would object to the admission of these affidavits.

[12] The Court: Have you submitted a counter-affidavit disputing these statements?

Mr. McKay: We do not have a counter-affidavit disputing a lot of the statements made in these affidavits, one of the reasons being that we would have to cross-examine the witness to find out whether some of the statements made were in fact accurate.

The Court: I thought that was why this case was recessed, to give you an opportunity to get the facts. And we recessed this case a couple of times for—

Mr. McKay: Yes, your Honor, we did.

The Court: —that purpose, to give you a chance to see what was what here.

Mr. McKay: That is true, to give us a chance to investigate the allegations made by the plaintiffs.

The Court: All right. Overruled. Received.

Mr. Goldfarb: For the record I would like to note the fact that in each of these affidavits, in the affidavit of Rae Wolper at Paragraph 6, it states that she received a verbal notice and at Paragraph 8 it states that she did not have access to the documents. In the affidavit of Rose Shulman, in Paragraph 7 it states that she received only verbal notice and in Paragraph 10 it states she did not receive any statements or any notice of [13] access to documents. In the affidavit of Bessie Rossoff, in Paragraph 8 it states that she received only verbal notice and in Paragraph 10 it states that she requested the documents and was denied access to her medical records. And in the affidavit of Pauline Ashkenazy, it states in Paragraph 8 that she received verbal notice and in Paragraph 10 it states that she requested documents but was not shown her medical records.

(Plaintiffs' Exhibit 6 received in evidence.)

Mr. Goldfarb: As to these four individuals, I would also like to introduce in evidence a mailgram which I received from the nursing home stating that "Unless you promise in writing to assure payments beyond the allocated 15-day grace period provided for fair hearing decision implementation," signed by both the Department of Health and the Department of Social Services, "we will, pursuant to rule, unfortunately, be forced to transfer those residents by the end of the working day of Thursday, 12/1/77. We await your response and thank you for your prompt consideration."

This is an exact copy of the message sent to Dr. N. Mishlin, care of New York State Department of Health, 2 World Trade Center.

The Court: Who sent the telegram and to whom?

[14] Mr. Goldfarb: The Park Manor Nursing Home. The original telegram went to the Department of Health.

He sent a copy to myself stating that he was transferring them unless there was either some type of court action or that the Department of Health guaranteed the Medicaid payments. We are introducing it to show the necessity and the harm that will come to our patients as proof that they will be transferred.

The Court: All right. Any objection to this? Let it be marked as Plaintiffs' Exhibit 7.

(Plaintiffs' Exhibit 7 marked for identification.)

Mr. McKay: Your Honor, I object to this as being irrelevant to the issues that are before the Court today. It involves a notice to the Park Shore Manor Home concerning the issue, or the statement, that these patients will be transferred due to Utilization Review Committee determinations that they no longer need the level of care provided at the home they are presently being cared for in. There is no question that when people are found ineligible to stay at one home that they will be transferred to another home with a lesser level of care. I don't see how this document adds to that general policy.

The Court: That is proof of the policy. That [15] is what this hearing is about, to prove what the plaintiffs claim. That is not a reason for not admitting the document. It doesn't go to the admissibility of the document. Overruled.

(Plaintiffs' Exhibit 7 received in evidence.)

* * *

[24] Mr. Gassel: Your Honor, at this time I would also like to mark for identification the two affidavits submitted by the State this morning. One is the affidavit of Donald B. Davidoff, with the exhibits attached to it. The other is the affidavit of William St[ei]bel, who is identified as Deputy Commissioner, Division of Medical As-

sistance, New York State Department of Social Services, and the attachment to it. * * *

* * *

[25] Mr. Gassel: [Exhibit] No. 10 [for identification] is Mr. Davidoff's affidavit [Record on Appeal Document No. 18] and [Exhibit] No. 11 [for identification] is Mr. Steibel's affidavit [Record on Appeal Document No. 20].

Q. Mr. Robert, I ask you to look at Exhibit 10 and Exhibit C of that exhibit, which is the hospital memorandum 77-119, and the notice attached to it.

I would also like you to look at Exhibit 11, and to Exhibit I of that Exhibit 11, which is administrative letter, 77 Adm 124.

You will notice, Mr. Robert, that there are annexed to one of those exhibits a form of a notice to be sent out to clients in cases of these Utilization Review or similar determinations.

* * *

Mr. Gassel: I am referring to Mr. Davidoff's affidavit, and Mr. Steibel's affidavit attached to Mr. [26] Davidoff's affidavit is hospital memorandum 77-119, which the State says it just issued, which is a purported new form notice, your Honor.

* * *

January 5, 1978 Order Issuing Preliminary Injunction and Dismissing Action Against City Defendant

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

CIVIL ACTION
No. 76 Civ. 3360 (CBM)

ORDER

WILLIAM YARETSKY, RALPH CUEVAS and THE GRAY PANTHERS, NEW YORK CHAPTER,

Plaintiffs,

vs.

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF and PAULINE ASHKENAZY, SADIE BIRENSWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY, and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Plaintiffs-Intervenors,

vs.

BARBARA BLUM, individually and as acting Commissioner of the New York State Department of Social Services; ROBERT WHALEN, M.D., individually and as Commissioner of the New York State Department of Health; and J. HENRY SMITH, individually and as Commissioner of the New York City Department of Social Services,

Defendants.

In the above-entitled action, a motion having been made by plaintiffs and plaintiffs-intervenors for the issuance of a preliminary injunction, and a motion having been

made by defendant J. Henry Smith for an order dismissing this action as against him on the grounds that he is not a proper party defendant herein, and the Court having certified this action as a class action on December 13, 1977, and the Court having conducted an evidentiary hearing on the above motions on January 4, 1978, and the Court having considered all the evidence presented at the hearing and the briefs, papers, and arguments of the parties, and the Court having issued its oral decision on January 4, 1978 granting defendant Smith's motion for dismissal and on January 5, 1978 granting plaintiffs' motion for a preliminary injunction, it is hereby

ORDERED (1), pursuant to Rule 21 of the Federal Rules of Civil Procedure, that the above-entitled action is dismissed as against defendant J. Henry Smith on the grounds that he is not a proper party defendant to this action; and it is further

ORDERED (2), pursuant to Rule 65 of the Federal Rules of Civil Procedure, that the defendants Barbara Blum, individually and as acting Commissioner of the New York State Department of Social Services, and Robert Whalen, individually and as Commissioner of the New York State Department of Health, and their successors in office, as well as their [CBM] officers, servants, employees, and agents including the proprietors and administrators of skilled nursing and health related facilities in New York State (hereinafter "nursing facilities"), and their respective employer and [CBM] agents, are hereby enjoined, and restrained pending a final determination of this action, from determining any of the plaintiffs-intervenors, in this action or any other person residing in a nursing facility in New York State who is a recipient of Medical Assistance (Medicaid) benefits (hereinafter "plaintiff class member")

to be ineligible to continue to receive the level of care at or to remain in the nursing facility in which he/she resides, from reducing or terminating the Medical Assistance (Medicaid) benefits of any plaintiff-intervenor or plaintiff class member for the level of care he/she is receiving, and from involuntarily transferring or discharging any such plaintiff-intervenor or plaintiff class member from the nursing facility in which he/she resides, unless in the case of any such plaintiff-intervenor or plaintiff class member the defendants afford such individual, after a recommendation by a Utilization Review Committee that such individual is ineligible to receive the level of care he/she is currently receiving, the following rights in addition to all other rights of that individual under law: (A) [CBM] timely and adequate written notice, given to the individual by a defendant or by an official of the State or a local Department of Social Services or Department of Health, that includes a statement of the proposed action, the specific regulations supporting such action, full [CBM] explanation of the individual's right to request an evidentiary state agency hearing, the circumstances under which assistance is continued if a fair hearing is requested, and the specific reasons for intended action in the form of a written statement setting forth in specific detail the changed medical conditions and other [CBM] circumstances of the individual which purportedly support the Utilization Review Committee recommendation that said individual no longer requires the level of care he/she is currently receiving, together with a copy of the completed form DMS-1, or form serving the function thereof, for that individual; and (B) [CBM] a fully adequate opportunity, and written notice of the right to that opportunity, for such individual and/or [CBM] his/her duly authorized representative to have unencumbered access to and to examine, at a reasonable time before the date

of that individual's fair hearing as well as during the hearing, the contents of all of that individual's case files and records and medical files and records, all documents and records to be used against that individual at the hearing, and all documents and records, medical or otherwise, which were relied on by the Utilization Review Committee in making the ~~initial~~ adverse recommendation, [CBM] including all of such medical documents and records which are at the nursing facility in which the individual resides; and it is further

ORDERED (3), that defendants and their employees and agents are enjoined and required to give to each plaintiff-intervenor and to each plaintiff class member who has already received an adverse Utilization Review Committee recommendation and who has not yet been transferred or discharged from his/her nursing facility a new notice and opportunity to have access to records and documents, in full accordance with the requirements of subparagraphs (A) and (B) of paragraph [CBM] (2) above; and it is further

ORDERED (4), that within 10 [CBM] business days after the date of the within Order, defendant Blum shall send, together with a copy of the within Order, an administrative letter or memorandum to every local or county Department of Social Services in New York State, and defendant Whalen shall send, together with a copy of the within Order, a hospital memorandum to every skilled nursing and health related facility in New York State, each stating that no plaintiff-intervenor and no plaintiff class member shall be transferred or discharged from his/her nursing facility or shall have his/her Medicaid benefits reduced or terminated unless such individual is afforded each and every right due him/her under this Order; and it is further

ORDERED (5), that defendant Whalen shall immediately send or cause to be sent a telegram to every skilled nursing and health related facility in New York State stating that the directive contained in hospital memorandum 77-122, dated 12/30/77 (attached hereto) [prohibiting the implementation of negative RHCF Utilization Review Committee determinations] shall remain in effect until further notice; and defendant Whalen may provide notice of the termination of said memorandum upon the transmittal of the hospital memorandum required by paragraph (4) above.

Dated: New York, New York
[CBM] January 5, 1978.
5:30 p.m.

/s/ CONSTANCE BAKER MOTLEY
United States District Judge

January 10, 1978 Opinion on Preliminary Injunction, Class Certifiation and Dismissal of City Defendant

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

[Title omitted in printing.]

[Appearances omitted in printing.]

CONSTANCE BAKER MOTLEY, D. J.

MOTION FOR PRELIMINARY INJUNCTION

Findings of Fact and Conclusions of Law

Plaintiffs are all elderly residents of skilled nursing home facilities and intermediate care facilities located in the State of New York. Each plaintiff is the recipient of Medicaid benefits made available as a result of New York State's medical assistance program. Each plaintiff has been notified that his or her benefits will be reduced or terminated, thus necessitating a transfer of plaintiff to a facility with a lower level of care.

The transfer becomes necessary because of plaintiff's inability to pay for the present level of care after reduction or termination of benefits.

The claim on this motion for preliminary injunction is that the determination to reduce or terminate plaintiff's Medicaid benefits in each instance was made without due

process of law in violation of the due process clause of the Fourteenth Amendment to the Federal Constitution and the federal and state statutes and regulations governing the Medicaid program. More specifically, plaintiffs claim that the determination in each case was made without: 1) adequate notice to plaintiff of the reasons for the determination and 2) without affording plaintiff, or his/or her representative an opportunity to examine the individual plaintiff's medical records at the nursing home facility in order that plaintiff might take meaningful advantage of the opportunity afforded for a review hearing and be prepared to refute the merits of the determination. Plaintiffs claim that the right to adequate notice and opportunity to discover, reasonably in advance of any hearing, relevant medical evidence and to present medical evidence at the hearing are rights protected not only by the Constitution but specifically provided for by the statutes and regulations. 45 CFR § 205.10(a)(4)(i)(B); 18 N.Y.C.R.R. § 358.8; 18 N.Y.C.R.R § 360.33(a)(1); 45 CFR § 205.10(a)(13).

This court's jurisdiction is therefore properly invoked under the provisions of Title 28, U.S.C. § 1343(3) and 1331(a) and Title 42, U.S.C. § 1983. *Feld* v. *Berger*, 424 F. Supp. 1356 (S.D.N.Y. 1976).

The State's program was established pursuant to the requirements of Title XIX of the Federal Social Security Act, 42 U.S.C. Sections 1396, *et seq.*, and regulations promulgated pursuant thereto. These statutes and regulations establish the standards which the State's program must meet and follow in order to qualify for federal financial assistance by way of reimbursement.

The State's program is administered by two State agencies, the Department of Social Services and the Department of Health. The Commissioner of each state

agency has been made a defendant in this action. The State's Department of Social Services is responsible under state law for administration of the entire public assistance program in the State, including the medical assistance program known as Medicaid. The Department of Health is responsible for administration of certain aspects of the Medicaid program and for licensing and supervising the operation of skilled nursing homes and other health-related facilities in New York State.

The funds provided each plaintiff by the State's program pay for that portion of the plaintiff's health care needs which the plaintiff is financially unable to meet and which are provided by the nursing home facility in which the plaintiff resides. Each plaintiff must therefore qualify both medically and financially for Medicaid benefits. This means that each plaintiff's entitlement to benefits and the level of such benefits are subject to periodic review and redetermination as required by statute. 42 U.S.C. § 1396a (26); 45 C.F.R. §§ 250.18(a)(1)(iii) and 250.19.

Pursuant to the review requirements, a Utilization Review Committee (the Committee) is required to be established in each skilled nursing facility (SNF) and each intermediate care facility (ICF) consisting of two or more physicians with participation from other professional personnel. The Committee cannot consist of physicians or other personnel on the staff of any facility or financially interested in such facility. 45 C.F.R. § 250.19(a)(3)(ii) (A) and (B). Patients in a SNF are to be reviewed by the Committee every 90 days to determine the need for continued stay and patients in an ICF are reviewed every 6 months. 45 C.F.R. § 250.19(a)(3)(viii) (B) and (4) (vi). The review of continued stay cases are conducted by the Committee or a designee of the Committee. (Brief of State Defendants filed 1/5/78, p. 4-5). Any case which does not meet the criteria developed to assess the neces-

sity for continued stay must be reviewed by a group which includes at least one physican. If the group does not believe that continued stay is medically necessary, it must notify the patient's attending physician and afford him an opportunity to present his views. If the attending physician does not present any additional information, the decision of the Committee is final. However, if the attending physician offers additional information and disagrees with the decision, two physicians must approve the Committee's decision. 45 C.F.R. § 250.19(a) (3) (ix), (C), (D), (E), (F) and (G).

Written notification of the Committee's decision is to be sent to the attending physician, the facility administrator, the patient, and where possible, his next of kin, and the single state agency in charge of the program. Notice must be given no later than two days after the final decision, but in no case later than three working days after the assigned review date. 45 C.F.R. § 250.19(a)(3)(ix)(F).

New York's regulations require that each facility comply with the foregoing federal regulations. 10 N.Y.C.R.R. §§ 416.9, 421.13 and 731.11. In New York the final determination that the continued stay is not medically necessary may be made by one physician where the attending physician does not contest the decision. 10 N.Y.C.R.R. § 731.11(j).

The federal and state regulations require that notice of termination or reduction be "mailed at least 10 days before the date . . . upon which the action would become effective." 45 C.F.R. § 205.10(a)(4)(i)(A); 18 N.Y.C.R.R. § 358.8(a)

The foregoing facts are not in dispute. What is disputed is 1) whether adequate notice was given as required to each plaintiff of the reason or reasons for the determination to reduce or terminate benefits and

2) whether plaintiffs or their representatives were given an opportunity to review the medical records at the nursing facility in order that they might take meaningful advantage of their right to a review of the determination and to present relevant medical evidence.

On the hearing of plaintiff's motion for preliminary injunction,[1] the evidence established that each plaintiff received some kind of notice and exercised his or her right to a review hearing, but in no case did a plaintiff receive the notice required by statutes and regulations governing the Medicaid program and in no case (except Foley) did a plaintiff have access to medical records at the facility in which that plaintiff was located (and which presumably formed the basis of the determination) at any time before or at the hearing.

In each instance a Department of Health form known as DMS-1 was filled out by a registered nurse at the nursing facility in which the plaintiff resides.[2] These forms constitute the first written recordation of the Committee's determination to transfer the plaintiff to a lower level of care. In addition to noting the patient's personal history, the DMS-1 form makes note of the diagnoses occasioning initial use of the facility, significant medications and surgery, if any, nursing care and therapy required, the patient's function status, mental status and impairments, whether the patient is incontinent, requires special diet, and a determination as to whether there is a high probability that complications would arise without

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[1] The motion for preliminary injunction was brought on by the intervenor plaintiffs, therefore all references to plaintiff in this case are to the intervenor plaintiffs. With respect to the two original individual plaintiffs, William Yaretsky and Ralph Cuevas, it is believed that Yaretsky is deceased and Cuevas has been discharged from his particular facility.

[2] Plaintiffs' Exhibits 6, 8.

skilled nursing care. This form in each case was signed by one physician who is apparently a member of the committee.

The form of written notice which each plaintiff thereafter received varied,[3] but showed conclusively that the reason given for the determination to reduce benefits and transfer the patient to a lesser care facility was vague and wholly conclusory. In the case of plaintiff Mary Foley, for example, her notification reads, in part, as follows: 'Our Utilization Review Committee has had a meeting as of April 14, 1977 and has recommended Miss Foley to a Health Related Facility. In the opinion of the physicians, she is not in need of skilled nursing care."[4]

In the case of plaintiff Rae Wolper, no written notification was given her as required. She was notified orally by a social worker in the facility in which she is located that a decision had been made to transfer her.[5] The social worker notified plaintiff Wolper of her right to a fair hearing which was thereafter requested. Neither plaintiff nor her representative received any documents or notice of where to obtain access to documents prior to the fair hearing.[6] At the hearing Miss Wolper's Form DMS-1 was introduced in evidence. This was the only evidence on which the State relied. Miss Wolper's medical records were not produced at the hearing. Miss Wolper's representative at the fair hearing, Beatrice Oaks, a paralegal, requested the opportunity to review this plaintiff's medical records on which the determination was ap-

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[3] Plaintiffs' Exhibits 6, 8.

[4] Plaintiffs' Exhibit 4. See also Plaintiffs' Exhibits 1, 2, 3, and 5 and 8.

[5] Plaintiffs' Exhibit 6.

[6] Plaintiffs' Exhibit 6.

parently made. The hearing was held at the nursing facility in which Miss Wolper resides. The request was denied. A similar request had been made before the hearing at the nursing facility. Miss Oaks, who represents nursing home patients, testified that she made a point of asking for the records in Miss Wolper's case to make sure that the policy was to refuse access to the underlying medical records since she represented other persons similarly situated.

Charles Robert, who represents nursing home patients in Nassau County, New York, testified to the same effect with respect to the availability of records and set forth in his affidavit specific instances when medical records were requested and not produced.[7]

In the case of Miss Wolper, the decision after the hearing reads in part as follows: "The record in this case establishes that the Utilization Review Committee reported to the agency on June 24, 1977 that appellant no longer required continued care in a Health Related Facility and recommended her transfer to an Adult Home. Although appellant objects to such transfer, she failed to present sufficient medical evidence to establish her need for continued care. . . . Accordingly, based on the medical evi dence presented at this hearing, the agency's determination was proper."[8]

Miss Wolper's private doctor had written a letter advising that her hypertension required close monitoring of her blood pessure, but this was viewed as insufficient ground for reversal of the original decision to transfer Miss Wolper from an ICF (Health Related Facility as distinguished from a Skilled Nursing Facility) to an Adult

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[7] Plaintiffs' Exhibit 9.

[8] Plaintiffs' Exhibit 6.

Home which has no medical facility or aid.[9] Since there was no access to the nursing home medical records by Miss Wolper's representative, and no records were produced at the fair hearing, the determination to transfer based on the Form DMS-1 could not be effectively challenged.

Plaintiffs Rose Shulman, Bessie Rossoff, and Pauline Ashkenazy all similarly received verbal notification from the social worker of the facility in which they reside of the decision to transfer. They were likewise represented at their fair hearing, which takes place at the facility, by Beatrice Oaks who testified that access to medical records was denied and that the only evidence relied on by the state was the Form DMS-1 in each case.

In the case of Sadie Birenzweig, the only notification was to her daughter who was verbally informed of the decision to transfer by the social worker.[10] She was represented at the fair hearing by her son and daughter. Mrs. Birenzweig was not present at the hearing, although her presence was requested by her son. The hearing again took place in the facility in which this plaintiff resides. Neither her son nor her daughter were shown any medical records at the hearing and were not told the basis of the decision. Mrs. Birenzweig is 93 years old. She has had two strokes, has severe cataracts in her eyes, is hard of hearing, walks with a walker, has arteriosclerosis, high blood pressure, arthritis and memory defects, according to her unchallenged affidavit. She has been in a skilled nursing facility for about one year. Plaintiff Martha Zahl is 87 years of age and has been in a skilled nursing facility since July 28, 1972. Plaintiff Edna Kolman is 87 years of age and has been in a skilled nursing facility for approximately nine years.

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[9] Plaintiffs' Exhibit 6.

[10] Plaintiffs' Exhibit 8.

Adequate notice is defined by the federal regulations as follows:

> "(B) 'Adequate' means a written notice that includes a statement of what action the agency intends to take, the reasons for the intended agency action, the specific regulations supporting such action, explanation of the individual's right to request an evidentiary hearing, . . . and the circumstances under which assistance is continued if a hearing is requested." 45 C.F.R. § 205.10(a)(4)(i)(B).

Under the State's regulations adequate notice is defined in part as follows:

> "(2) *Adequate advance notice* means a written notice that includes details of reasons for the proposed action, . . ." 18 N.Y.C.R.R. § 358.8(a).

The court finds that the "adequate" written notice was not given to plaintiffs or their next of kin or representatives. In those cases where written notice was given that written notice was manifestly inadequate to advise the plaintiff of the underlying medical reasons for the decision to transfer.

In *Feld* v. *Berger,* 424 F.Supp. 1356 (S.D.N.Y. 1976) this Court (Weinfeld, J.) has already ruled that a Medicaid claimant or his representative is entitled to "timely" notice and an opportunity to examine his or her file at a reasonable time before the hearing and at the hearing in accordance with federal regulations. 45 C.F.R. 205.10(a)(13)(i). This includes the right to examine all documents and records to be used by the State at the hearing. And there appears to be no statutory or other bar to a request to review a claimant's file, *after a decision to transfer has been made* by the Committee and claimant so notified, in

order that the claimant or his or her representative can make an informed decision whether to request a hearing. To invoke the right to review without any basis therefor is certainly not to be encouraged in the context of Medicaid fair hearings any more than it is to be encouraged in any other legal context. The State suggested at the hearing of plaintiffs' motion for preliminary injunction that plaintiffs' right to see the medical records arises only after the plaintiff has requested a fair hearing as the regulation reads, then if plaintiff finds there is no basis for an appeal, plaintiff can then withdraw the request for a hearing. This suggestion was made in reply to plaintiffs' request to be allowed the right to see the records after the Committee determination. The court sees no logic in this suggestion. It seems far more logical and far more consonant with the spirit of the regulations to permit a plaintiff to see the records, when requested, before an appeal is needlessly invoked. The suggestion that the records contain information which might upset the patient if it became known has already been raised and rejected. *Feld* v. *Berger, supra,* at 1363.

The record discloses that Foley apparently had access to nurses notes. Her representative did not see prior DMS-1 forms for comparison with the current one relied on by the State.

The court finds that plaintiffs have shown a clear probability of success on the merits of their claim that they are entitled to "adequate" notice and an opportunity to see the medical records before and at the hearing as required by federal regulations. In *Feld* v. *Berger, supra,* although Judge Weinfeld referred specifically to the requirement of "adequate" notice the issue there emphasized was "timely" notice, i.e. whether persons such as plaintiffs are entitled to notice at all. A statement of the underlying medical reasons for termination or reduction, as the

Federal and State regulations require, are manifestly necessary in order to enable a Medicaid claimant to prepare an intelligent appeal or to conclude that no appeal is warranted. Plainly no hearing can be labeled fair which permits a Medicaid recipient to learn for the first time on appeal of the specific medical reasons for reduction or termination of Medicaid benefits.

It is too plain for argument that there is a possibility that these elderly and medically disabled plaintiffs will suffer irreparable harm if they are transferred from a SNF or an ICF in violation of statutory notice and fair hearing requirements. *Feld* v. *Berger, supra,* at p. 1359.

As Judge Weinfeld noted in *Feld* v. *Berger, supra,* at p. 1360 n. 12, the federal due process claims here are not frivolous. Medicaid benefits on which plaintiff must depend are being reduced or terminated. *Goldberg* v. *Kelly,* 397 U.S. 254 (1970). At stake for these plaintiffs are two fundamental interests which are constitutionally protected. These plaintiffs are being threatened with an action that for many of them will result in eviction from what is now their home. And in every case the plaintiff will sustain a reduction or termination of public assistance in the form of Medicaid benefits. In such a case, the due process clause requires minimum procedural safeguards which includes adequate notice of the *reasons* for reduction or termination and opportunity to be heard which includes an opportunity to discover and present evidence.

Consequently there are also sufficiently serious questions raised by plaintiffs going to the merits of their constitutional claims as to make them a fair ground for litigation with the balance of hardship tipping decidedly toward these plaintiffs. Plaintiffs have therefore met their burden on this motion for preliminary injunction. *Gresham* v. *Chamber,* 501 F.2d 687 (2d Cir. 1974).

This case has not been rendered moot by the new notice form issued by the Department of Health on 12-30-77.[11] That form, if applicable to plaintiffs, likewise fails to require *reasons* for the determination to reduce or terminate benefits and to advise plaintiffs and members of their class of their right to see their medical records at the nursing home in advance of the fair hearing.

An injunction will therefore issue enjoining defendants, pending a final determination of this action, in two respects: First, defendants will be enjoined from failing and refusing to provide each plaintiff, and others similarly situated, with reasons for any agency action, the result of which would be to transfer the plaintiff from the facility in which the plaintiff is presently residing to a lesser care facility or to otherwise reduce the amount of Medicaid assistance available to plaintiff. Second, defendants will be enjoined from refusing to permit plaintiff's access to all medical records of plaintiffs at the nursing home after the Committee decision.

Class Action Certification

This action was originally filed on July 28, 1976 on behalf of two individuals, William Yaretsky and Ralph Cuevas and the New York Chapter of the Gray Panthers. The State defendants answered on December 13, 1976. On April 8, 1977 an amended complaint was filed on behalf of the original plaintiffs and other persons similarly situated praying for class certification. On November 23, 1977 Mary Foley filed an intervenor complaint. On November 30, 1977, Rae Wolper, Rose Shulman, Bessie Rossoff and Pauline Ashkenazy filed an intervenor complaint. And on December 12, 1977 Sadie Birenzweig,

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[11] Plaintiffs' Exhibit 13.

Martha Zahl, Edna Kolman, James Lundy and Philomena Latona Lundy filed an intervenor complaint.

On December 5, 1977 plaintiffs Mary Foley, Rae Wolper, Rose Shulman, Bessie Rossoff and Pauline Ashkenazy, were permitted to intervene and were granted a temporary restraining order restraining defendants, including their agents, the proprietors and manager of the Parkshore Manor nursing home, from discontinuing the eligibility of the plaintiffs-intervenors to remain in the facility as patients and from failing to continue uninterrupted their full levels of Medicaid assistance benefits for intermediate nursing care, and from transferring plaintiffs from the Parkshore Manor health related facility. J. Henry Smith, City Commissioner of the Department of Social Services was joined as a party defendant.

On November 22, 1977 intervenor plaintiff Mary Foley moved for a preliminary injunction on behalf of herself and others similarly situated. On November 28, 1977, this court entered an order setting a hearing for December 8, 1977 on the Foley motion, permitting Foley to intervene and restraining defendants from terminating her benefits pending the hearing.

On December 14, 1977 a similar order was entered on behalf of Foley, Wolper, Shulman, Rossoff, Ashkenazy, Birenzweig, Zahl, Kolman, James Lundy and Philomena Latona Lundy setting a hearing on a new motion for preliminary injunction for December 20, 1977, permitting Birenzweig, Zahl, Kolman, and the two Lundys to intervene, certifying the action as a class action, and issuing a temporary restraining order on behalf of these intervenors.

In *Feld* v. *Berger, supra,* plaintiffs had moved for class action determination. Judge Weinfeld ruled that he deemed class certification superfluous. In this connection he said: "The defendants are public officials charged with

compliance with and enforcement of federal as well as state laws. The Court assumes these public officials, mindful of their responsibilities, will apply the determination here made equally to all persons similarly situated. '[I]t would be unthinkable that the . . . defendants would insist on other actions being brought' to vindicate the same rights at issue here." He cited *Vulcan Society* v. *Civil Service Commission,* 490 F.2d 387, 399 (2d Cir. 1973) and other cases in support of his determination that class action certification would be unnecessary.

The defendants in the *Feld* case were the Commissioner of the New York State Department of Social Services and the Commissioner of the New York City Department of Social Services. The instant case and the *Feld* case were pending at the same time and, apparently, since Judge Weinfeld rendered his decision in the *Feld* case on December 28, 1976 holding that SNF and ICF patients were entitled to timely notice and also to an opportunity to review records prior to a hearing the instant action was not pressed. However, when it appeared that defendants in *Feld* were not complying with Judge Weinfeld's order, the intervenor plaintiffs here sought to intervene in this action which was awaiting class action certification, to move for such certification, and for preliminary relief.

As this Court has found, defendants here have not complied with the federal or state regulations with respect to "adequate"notice and have not allowed, with one possible exception, discovery of medical evidence in the nursing home file prior to a state fair hearing, contrary to the belief expressed by Judge Weinfeld that they would comply with the regulations and that additional legal action in this area would be unnecessary. Since Judge Weinfeld denied class action certification, the intervenors apparently concluded that they had no alternative except to intervene in this action and press for class certification or bring still

another action. This court previously ruled from the bench that the case would be certified as a class action in order to stem the flow of intervenor petitions. This determination is now reaffirmed and the court certifies that this action is properly maintainable as a class action.

What plaintiffs actually seek is certification of a sub-class, for the purposes of this motion for preliminary injunction, consisting of plaintiffs who have been determined by defendants to be ineligible to remain in the facility in which they presently reside and who have been denied by defendants adequate notice and access to documents and evidence prior to their fair hearings. That certification is granted. Rule 23(c)(1),(4). The court finds that the sub-class is so numerous that joinder of all members is impracticable. As indicated, there have been 10 individuals who have been allowed to intervene and counsel for these intervenors advised the court that others were seeking intervention. It appears from the evidence that there are numerous other persons similarly situated, all of whom need immediate relief from this court to prevent irreparable injury. The court also finds that there are common questions of law and fact relating to the sub-class. Rule 23(a)(2). These questions are whether defendants' failure to afford plaintiffs and members of their class "adequate" notice and discovery of relevant documents and evidence violates rights to due process and federal and state statutory requirements. The court finds that the claims of the representative parties are typical of other members of sub-class and that the plaintiffs will adequately represent the class. Counsel for intervenor plaintiffs are the Legal Aid Society of the City of New York, and the Legal Services for the Elderly Poor. Mobilization For Youth represents the original plaintiffs. These organizations have the legal resources and experience adequate to protect members of the sub-class and

are able to utilize their resources to protect the interest of all members of the sub-class. Rule 23(A)(4). Plaintiffs counsel have brought to the court's attention a number of class actions prosecuted by them on behalf of various plaintiffs in this court and other federal courts. Finally, the court finds that defendants have acted or have refused to act on grounds generally applicable to the sub-class thereby making appropriate final injunctive and other relief to the sub-class as a whole. Rule 23(b)(2). The court finds that the plaintiffs are not only entitled to have this action certified as a class action, *Percy* v. *Brennan*, 384 F.Supp. 800, 811 (S.D.N.Y. 1974); *Rodriguez* v. *Purcell*, 391 F.Supp. 38, 41 n.12 (S.D.N.Y. 1975), but that the class action is absolutely necessary to avoid further duplication of litigation with respect to the administration of the State's Medicaid program relating to long term nursing care facilities for the elderly.

The City's Motion To Dismiss

On January 3, 1978 the defendant New York City Commissioner of Social Services had moved to dismiss the action as to him on the ground that the state has taken charge of long term cases in the Medicaid field and the city is therefore not a proper party to this proceeding. The evidence at the hearing on plaintiffs' motion for preliminary injunction disclosed that as of July 5, 1977 the State Department of Health moved by a Hospital Memorandum of that date to supercede all other prior instructions regarding patients in or being admitted to Residential Health Care Facilities.[12] This action was taken pursuant to the New York State Legislature action in passing Medicaid cut-back legislation. (Chapter 77 of the Laws of 1977).

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[12] Plaintiffs' Exhibit 14.

This memorandum sets forth the procedure for determining whether a patient is to be admitted to or continued in a particular facility.

On December 30, 1977 another Hospital Memorandum was issued by the State Department of Health advising skilled nursing facilities and health related facilities of their responsibility to notify Medicaid patients of their right to a fair hearing when Medicaid benefits are to cease because the present level of care is found to be unnecessary, inappropriate, or not a covered Medicaid benefit, and directing that such notification be made in writing.[13] It is therefore clear that as a result of the Medicaid cut-back legislation the State Department of Health has moved to take control of the utilization review process and continued aid process action. The City Commissioner of Social Services is, therefore, at the very least, an unnecessary party. Even if a city agency does perform some function with respect to the reduction or termination of the benefit as the local paying agent, this is done only after the determination has been made by the Committee at the facility pursuant to federal and state regulations and after a fair hearing. The city defendant's motion to dismiss is, therefore, granted.

Dated: New York, New York
January 10, 1978

s/ Constance Baker Motley
U. S. D. J.

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[13] Plaintiffs' Exhibit 13.

February 17, 1978 Order Denying State Defendants Relief From January 5, 1978 Order Requiring Them to Notify Patients of Adverse Utilization Review Committee Decisions[*]

Motion to amend order to permit notice to be sent by facility as opposed to the state [CBM] [or] local public agency which makes the determination to discontinue or reduce benefits denied. Notice must be given by the latter.

So Ordered,

2/17/78 N.Y., N.Y.

s/ Constance Baker Motley
U.S.D.J.

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[*] Handwritten endorsement by the district judge, document number 32 of the record on appeal, appears on the back of document number 29.—Ed.

January 16, 1979 Opinion of the Court of Appeals

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

No. 13—August Term, 1978.

(Argued October 12, 1978 Decided January 16, 1979.)

Docket No. 78-7077

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, New York Chapter,

Appellees,

—and—

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY, and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Intervenors-Appellees,

—v.—

BARBARA BLUM, individually and as Acting Commissioner of the New York State Department of Social Services, ROBERT WHALEN, M.D., individually and as Commissioner of the New York State Department of Health,

Appellants.

Before:

LUMBARD and OAKES, *Circuit Judges*, and MACMAHON, *District Judge.**

Appeal from an order of the United States District Court for the Southern District of New York, Constance Baker

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* Of the Southern District of New York, sitting by designation.

Motley, *Judge*, granting a preliminary injunction against proposed changes in the procedure for notifying residents of health care facilities of (1) decisions to transfer them to reduced care facilities, which entail a reduction or termnation of benefits, and (2) the patients' right to fair hearings to challenge such decisions. Held, this court has jurisdiction over the appeal even though appellants filed the notice of appeal during the pendency of a motion to amend the preliminary injunction; the district court correctly enjoined defendants from delegating to the health care facility the responsibility for notifying the patient of his fair hearing rights; and the district court properly refused to allow defendants to exclude "medically contraindicated" information from the records to which the patient may have access in order to prepare for the fair hearing.

Judgment affirmed.

[Appearances omitted in printing.]

PER CURIAM:

This is an appeal from an order of the United States District Court for the Southern District of New York, Constance Baker Motley, Judge,[1] dated January 5, 1978, but filed January 10, 1978. The order granted appellees' motion for a preliminary injunction against appellants to prevent them from failing to provide resident patients in health care facilities with timely and adequate written notice of the decision to transfer them to a reduced care facility and to reduce or terminate their Medicaid benefits. On January 19, 1978, appellants filed a motion under Fed. R. Civ. P. 59(e) to amend the preliminary injunction to allow the health care facility itself to provide the notice

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[1] *Yaretsky* v. *Blum*, No. 76 Civ. 3360 (CBM) (S.D.N.Y. Jan. 10, 1978).

required of the state or local supervisory agencies and to withhold from the patient information in his file if disclosure was "medically contraindicated." On February 6, 1978, while the motion was pending, appellants filed a notice of appeal from the preliminary injunction. On February 21, 1978, the district court denied appellants' Rule 59(e) motion. On appeal, appellants raise essentially the two points that they made in the Rule 59(e) motion. Appellees defend on the merits the district court's preliminary injunction as issued, and thus the district court's denial of the Rule 59(e) motion, but they also question this court's jurisdiction over the appeal. We address the jurisdiction issue first.

Appellees argue that the notice of appeal was filed during the pendency of the Rule 59(e) motion and a premature notice of appeal is "a legal nullity." Appellants suggest that because they filed the Rule 59(e) motion fourteen days after the date of the district court's order, albeit nine days after the date of the filing of the order, the motion was untimely and thus did not toll the period for filing the appeal. We hold otherwise, however.

Although the district court's order was dated January 5, 1978, the clerk entered the order in the docket on January 10, 1978. Under Fed. R. App. P. 4(a), which speaks of the "entry of judgment" as the crucial date, and Fed. R. Civ. P. 58 and 79(a), which provide that a judgment becomes effective only when entered in the docket, the date of the entry in the docket, not the date of the order, begins the running of time for post-trial motions and appeals. *See, e.g., Neely* v. *Merchants Trust Co. of Red Bank,* 110 F.2d 525 (3d Cir. 1940); *see* 6A *Moore's Federal Practice* ¶ 58.03[1] (2d ed. 1973).

The appeal was thus premature. Although the filing of a notice of appeal within the prescribed time limits is a

jurisdictional prerequisite to the appeal itself, the better rule is that in the absence of prejudice to the appellee, the court should treat a premature appeal as from a final judgment so as to avoid denial of justice, expense, and inconvenience. This rule applies to appeals that are premature not only because they were filed between the pronouncement of judgment and the entry of judgment, *see Lemke* v. *United States*, 346 U.S. 325 (1953), but also because they were filed while a Rule 59 motion was pending. *See, e.g., Dougherty* v. *Harper's Magazine Co.*, 537 F.2d 758, 762 (3d Cir. 1976); *Stokes* v. *Peyton's Inc.*, 508 F.2d 1287 (5th Cir. 1975); *Song Jook Suh* v. *Rosenberg*, 437 F.2d 1098 (9th Cir. 1971); *see* 15 C. Wright, A. Miller & E. Cooper, *Federal Practice and Procedure* § 3915, at 599-600 (1976). Appellees have alleged no prejudice, nor could they, because they had notice of the grounds for appeal from the Rule 59(e) motion itself.

We thus reach the two issues raised on the merits. Appellants argue first that the district court erred in refusing to allow the health care facility itself to provide the notice to the resident patient of the decision to transfer him to a reduced care facility and to reduce or terminate his Medicaid benefits. The district court's order, which enjoined appellants from implementing this single notification procedure, required adherence to the dual notification procedure previously in effect. Under that procedure, the facility's Utilization Review Committee informs the patient of its decision that his continued stay at the facility is not medically necessary and that a lower level of care would be more suitable to his condition; the local social services agency or office then notifies the patient of his right to a fair hearing to review the Committee's decision and the due process rights to which the patient is entitled at the hearing. Appellants contend, although we note that there is no supporting evidence in the record, that the

dual notification procedure "proved to be cumbersome to administer, inefficient and confusing to the patient" and that the single notification procedure, by contrast, "would benefit the patient and help streamline the complex network of Medicaid regulations." But regardless of how we may feel about seemingly unnecessary bureaucratic red tape, the HEW regulations clearly require the state or local agency to provide the notice of transfer or reduction or termination of benefits, 45 C.F.R. § 205.10(a)(4)(i),[2] and further seem to preclude delegation of the responsibility. *Id.* § 205.100(b)(1).[3] Appellants cite no authority for allowing a private party such as the health care facility to provide the notice required by due process before the State can reduce public assistance benefits.

Moreover, it is not irrational to treat the functions of the Utilization Review Committee and the state and local social services agencies as diverse. As a part of the process of keeping a patient informed about his condition and proposed medical treatment, the Committee is the one to inform the patient of the decision to reduce the level of care that he is receiving; consistent with this doctor-patient framework, 42 C.F.R. § 450.19(a)(3)(ix)(F) requires the

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[2] 45 C.F.R. § 205.10(a)(4)(i) provides that "the State or local agency shall give timely and adequate notice" in cases of proposed actions to reduce or terminate assistance. It does not permit notice to be given by a private party or "the Utilization Review Committee" of a private party.

[3] 45 C.F.R. § 205.100(b)(1) permits delegation "by other State or local agencies" but in no case permits delegation to a private party such as a health care facility or its "Utilization Review Committee." The dissenting opinion appears to equate such a committee with a state or local agency, a characterization with which we disagree; and we note that appellants make the further argument that *either* the Utilization Review Committee *or* the private health care facility itself should be allowed to provide the patient with notice of the reduction or termination of his Medicaid benefits and his fair hearing rights to challenge this determination.

Committee to provide this preliminary notice. The state agency, however, bears ultimate responsibility for informing the patient of the resulting reduction or termination of his health care benefits and advising him of his due process rights to a hearing to review the Committee's decision. If, as appellants contend, the proposed single notification system is clearly superior and would not result in the failure of patients to receive written notice of their fair hearing rights, as happened to appellees in this case, the remedy lies in persuading HEW to amend its regulations.[4] Neither appellants nor the court can unilaterally change the federally imposed notification procedure.

Appellants also challenge, in a somewhat appealing argument, the district court's refusal to exclude "medically contraindicated" information from the scope of the disclosure required of the agency to the patient preparing the defense that he will use at the fair hearing. The HEW regulations provide that "[t]he claimant, or his representative, shall have adequate opportunity . . . [t]o examine the contents of his case file and all documents and records to be used by the agency at the hearing at a reasonable time before the date of the hearing as well as during the

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[4] In support of the suggested preference for the judgment of the state officials over that of the district court, the dissenting opinion states that "some patients will not receive notice under either system so long as it is administered by fallible human beings." However, the undisputed evidence is that none of the ten intervenor-appellants received *any* written notice whatsoever; the "notice" given to them was either a verbal notice to the patient, written or verbal notice to the patient's relative, or a combination of the two; and the "notice" was brief and conclusory, stating only that the patient would be transferred and that the patient could seek a fair hearing. Thus even if the notice procedure in this case had been proper, it was woefully inadequate. In addition, the burden, it seems to us, is on the State to presuade HEW to amend its regulations, not on private plaintiffs first to complain to HEW.

hearing." 45 C.F.R. § 205.10(a)(13)(i). Thus the regulations requiring disclosure do not facially exempt medically contraindicated information. *See Feld* v. *Berger*, 424 F. Supp. 1356, 1363 (S.D.N.Y. 1976); *cf. Areizaga* v. *Quern*, 442 F. Supp. 168, 172-73 (N.D. Ill. 1977) no exemptions from disclosure); *Dunbar* v. *Toia*, 61 App. Div. 2d 914, 403 N.Y.S.2d 4 (1st Dep't), *aff'd*, 45 N.Y.2d 764, 380 N.E.2d 321, 408 N.Y.S.2d 495 (1978) (same). Moreover, an exemption for medically contraindicated information would tend to frustrate the purpose of the requirement of disclosure. As appellees point out, very often the medically contraindicated information will be the information most useful to a patient in contesting an adverse Utilization Review Committee decision. If the information indicates a condition or prognosis unfavorable enough to upset the patient severely, perhaps it also is unfavorable enough to provide the patient with a defense against the Committee's determination that he does not require a continuation of the level of medical care that he has been receiving.

Appellant's brief on appeal argues that failure to disclose to the patient medically contraindicated information would not make the information unavailable to the patient at the fair hearing. Appellants wish to "emphasize[] that the information withheld from the patient himself will be disclosed to the patient's representative or relative." But, as appellees point out, a substantial proportion of health care facility patients may not have a representative or relative sufficiently concerned about their well-being to seek out and present at the fair hearing the withheld information. The appropriate position lies in between: if the state or local agency will guarantee that it will provide representation to the patient from whom it seeks to withhold medically contraindicated information and that it will disclose to the representative this information, then the information may be withheld from the patient.

Absent such a guarantee the preliminary injunction must be upheld. Appellants may, of course, apply to the district court to modify the injunction when they are ready, willing, and able to provide the required representation.

Judgment affirmed.

LUMBARD, *Circuit Judge* (concurring in part and dissenting in part):

I dissent from so much of Judge Oakes' opinion as requires the continued maintenance of the dual system of notification which the state officials in charge have found to be "cumbersome to administer, inefficient, and confusing to the patient." I would hold that the appellants' decision to implement a single notification system in place of the older dual notification system is within the realm of discretion allowed to them by the relevant regulations.

The majority, however, has concluded that "regardless of how we may feel about seemingly unnecessary bureaucratic red tape, the HEW regulations clearly require the state or local agency to provide the notice of transfer or reduction or termination of benefits, 45 C.F.R. § 205.10(a)(4)(i), and further seem to preclude delegation of the responsibility. *Id.* § 205.100(b)(1)."

Although the majority has not thought it necessary to quote from the regulations themselves, an examination of their text will indicate why my reading of these regulations differs so markedly from their reading.

45 C.F.R. § 205.10(a)(4)(i) provides that:

> A State [Medicaid] plan shall provide for a system of hearings under which . . . The single State agency responsible for the program shall be responsible for fulfillment of hearing provisions. . . . In cases of intended action to discontinue, terminate, suspend, or re-

> duce assistance . . . the State or local agency shall give timely and adequate notice. . . .

45 C.F.R. § 205.100(b) provides that:

> The State agency will not delegate to other than its own officials its authority for exercising administrative discretion in the administration of supervision of the plan including the issuance of policies, rules, and regulations on program matters. . . . In the event that any services are performed for the single State agency by other State or local agencies, such agencies and offices must not have authority to review, change, or disapprove any administrative decision of the single State agency, or otherwise substitute their judgment for that of the agency as to the application of policies, rules, and regulations promulgated by the State agency.

Read in their entirety, these provisions of the C.F.R. carry a plain meaning. § 205.10(a)(4)(i) simply provides that the state agency is ultimately "responsible" for giving "timing and adequate notice. . . ." If this choice of words carries an implicit prohibition against delegation of duties even where the state agency retains ultimate responsibility to ensure that those duties are carried out properly, I fail to see it. In any event, § 205.100(b) clearly provides for the delegation of all duties imposed under the plan except for those functions which necessarily involve "discretion" or "supervision" such as would be involved in the "issuance of policies, rules, and regulations on program matters. . . ." The regulation explicitly permits the delegation of agency functions to other State or local agencies and offices, such as the Utilization Review Committee (URC), provided that these delegates have no authority to "review, change, or disapprove" decisions as to the application of the rules and regulations and as to the determination of policy decisions

generally. The delegates cannot "substitute their judgment" for the judgment of those responsible for running the program. Thus the regulations make the familiar distinction between discretionary, managerial, and policy-making tasks, which clearly cannot be delegated, and ministerial tasks, involving little or no exercise of discretionary judgment, which just as clearly can be delegated.

The issue before the court is whether the URC or the state agency will send a printed form to the Medicaid recipient advising him of his due process rights. Since the form must be sent whenever there is a reduction or termination of benefits, there is no discretionary or policy-making judgment involved in deciding when to send the form. And since all that is required is to place the form in an envelope and mail it, no discretionary or policy-making judgment is required in deciding how to send the form. Indeed, sending out these printed forms appears to be one of the most paradigmatically ministerial—and therefore delegable—tasks imaginable. If mailing forms cannot be delegated, I am hard put to think of what can be. Yet the reasoning of the majority opinion might be read to suggest that not only the placing of the forms in the envelopes must be carried out by agency officials, but that these officials must hand deliver each notice in person, rather than delegating the purely ministerial task of delivery to the United States Post Office.

That appellants have not, as the majority notes, cited any "authority for allowing a private party such as the health care facility to provide the notice required by due process before the State can reduce public assistance benefits" cannot require a different result. First, the absence of authority, to the degree it exists, springs from the utter futility of challenging delegation of such a purely ministerial function. Second, the URC, which the state officials would like to entrust with the ministerial task of providing

notice, is not a "private party [like] the health care facility," but rather, a public agency, whose establishment is required as a condition of participation in the Medicaid program, and which is given discretionary as well as notice responsibilities of its own. See 42 C.F.R. § 450.19(a)(3)(ix)(F). To prohibit a public agency with discretionary and managerial responsibilities from carrying out ministerial tasks at the direction of the state agency of which it is a part would be anomalous indeed. The plain meaning of the regulations cannot support such a result.

Moving beyond the regulations, I believe that there are other equally important reasons for reversing the district court's requirement that the dual notification system be maintained. First, the district court did not give sufficient deference to the determination of the state agencies that the dual notification system was "cumbersome to administer, inefficient and confusing to the patient," and that the single notification system, by contrast, "would benefit the patient and help streamline the complex network of Medicaid regulations." In addition to saving the extra expense of a duplicative system, the single notification system works to the patient's advantage by advising him simultaneously of both the URC decision and of his right to challenge that decision. Although some patients will not receive notice under either system so long as it is administered by fallible human beings, that is no reason for preferring the judgment of the district court to the judgment of state officials

who are entrusted with running these programs, who are intimately acquainted with the problems involved, and whose duty and interest is to see the program run smoothly. Where, as here, such officials make changes in the program within the realm of the discretion permitted to them under the regulations, their decisions are entitled to considerable deference by the federal judiciary.

Second, I believe that private plaintiffs who have not exhausted their administrative remedies bear an especially heavy burden in seeking to have a federal court upset a carefully considered state agency decision, particularly when they cannot refer to even one regulation prohibiting that decision. The federal courts are not ombudsmen. Plaintiffs should have brought their complaint in the first instance to HEW which is charged with administering the Medicaid program and which presumably has more expertise in this area than federal judges. Indeed, plaintiffs have not even bothered to find out what HEW's position on this matter is. Certainly we should be aware of HEW's position before we hazard a decision which may interfere with a complicated regulatory scheme. *Burford* v. *Sun Oil Co.*, 319 U.S. 315 (1943). If HEW is not satisfied with the manner in which the state is carrying out the program it has the duty and the authority to take the necessary action.

Deposition of Anthony J. Maddaloni (Excerpts)

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

[Title omitted in printing.]

Two World Trade Center
New York, New York

October 26, 1978
2:00 P.M.

Deposition of ANTHONY J. MADDALONI, taken by the Plaintiffs, pursuant to Notice dated October 19, 1978.

[2] [Appearances omitted in printing.]

* * *

[3] ANTHONY J. MADDALONI, having been first duly sworn by a Notary Public of the State of New York, was examined and testified as follows:

Examination by Mr. Gassel:

Q. Would you state your full name, please. A. Anthony J. Maddaloni.

* * *

[4] Q. By whom are you employed? A. New York State Department of Health, Office of Health Systems Management.

Q. How long have you been at the Department? A. About two years, four months.

Q. What did you do before that? A. I was a business manager in a nursing home.

Q. Where was that? A. In Schenectady, New York.

Deposition of Anthony J. Maddaloni

Q. What is your job title? A. Associate Medical Care Administrator.

Q. Stripped of jargon, what do your duties entail? A. Responsible for coordinating and administrating all of the medical care programs under the Medicaid program.

Q. Whom do you supervise in that respect? A. A number of health professionals, administrators that deal with PMR's, periodic medical reviews, IPR's, independent professional reviews, the utilization review functions, DMS1's and the over-all Medicaid long-term care programs.

* * *

[10] Q. Mr. Maddaloni, you have been giving your answers in numbers of beds rather than patients. What is the over-all vacancy rate in New York, the average? A. I would imagine it would fluctuate. The Health Plan Commission would be responsible for tabulating vacancy rates.

Q. Is your information that the occupany rate is over 95 per cent generally throughout the state? A. The last figure that was presented to me was 93 per cent upstate and 91 per cent in the downstate area.

Mr. Kay: Are we talking now about SNF's, HRF's or both?

The Witness: We are talking about both.

Mr. Kay: The combined figure?

The Witness: Right.

* * *

[35] Q. What is the purpose of PMR then? A. The PMR and the IPR are Federally-mandated reviews to insure the quality of care, the accuracy or appropriateness of placement and whether or not the needs of the individuals within the nursing homes are being met.

Examination by Mr. Robert:

Q. The PMR is to set a quality control system [36] as to whether the medical records are accurate; is that cor-

rect? A. It is to determine whether the medical records accurately reflect the patient. However, it is more importantly a hands-on review of the patient to determine the care that they need is being received.

It is a quality insurance on care, not a quality insurance on how do you complete your medical records. The surveys would review the over-all operations and structure of the facility to determine that aspect.

Q. Is that because the provider himself has a higher error factor than what the government would like? Why are we monitoring these providers? Are they making mistakes? A. The Federal regulations require that for New York State to receive Federal financial participation, that we perform periodic medical reviews and independent professional reviews within RHCF settings. It is to determine and to insure that quality care is provided to patients. It is the same type of review that will be performed in hospitals by the JCAH to insure that that particular component—

Q. Is there any expectation that the provider is making mistakes? [37] A. No, I don't believe that that is the expectation. I think, like any regulation, you insure that certain things occur that are mandated in regulations, that you cannot just take it for granted, just as you could not take for granted that every driver would enforce a 55-mile limitation.

(Brief recess.)

By Mr. Gassel:

Q. Is your particular division, Mr. Maddaloni, responsible for implementation, supervision of the DMS1, how it is implemented by the facilities? A. Yes, we are responsible for surveying and monitoring the over-all utilization review program.

Q. And you were the people who put it out, put out the memoranda which implemented the system? A. Well, we, meaning the Office of Health Systems Management, reorganized from the time that the initial form was completed. However, the components, the units, are essentially the same.

* * *

[48] By Mr. Gassel:

Q. Have you made any cost benefit studies on the use of the DMS1 or the operation of utilization review to determine whether it is cost efficient? A. No, I don't know of any reports or studies that have come out of my office. That is not to say that somewhere in the Department they may not exist. The UR process is a Federally-mandated program, so whether or not we felt it was efficient or not would not preclude us from endorsing a Federally-mandated program.

Q. Well, there are administrative alternatives available to you, restructuring the system or going to a multilevel or some system or something like that. Has anybody done a cost benefit of those? A. Even with, say, a multilevel facility, a patient's condition would still not preclude the need for a utilization review committee.

Q. Have you determined how many patients, as a result of going through this process, are actually as a rule transferred to a lesser cost care and therefore financially benefit the state? A. There is really no documentation, as I said [49] earlier, to tell us how many patients moved because of the UR.

They can move by way of their attending physician saying, "I want my patient here to go from the skilled nursing to the health related, because it would be better for him."

It doesn't go through the UR Committee's functions.

Q. Have you done any follow-ups on patients who have been moved to a different level of care as a result of this process? Any follow-up of patients who have been transferred to see if patients are being transferred as a result of this process? A. Well, if patients were being transferred for any reason, there would be a back-up in the system sooner or later. As far as any studies to say what happens to a patient after—

Q. I am sorry, I want to make sure we are talking about the same thing.

When I said transferred, I meant transferred to other levels of care, and I sense that you were using it, correct me if I am wrong, in the larger sense you used it before, including, say, a trip to the hospital and so forth or discharge home.

[50] A. You are just talking about, we'll say, internal or even external transfers within the RHCF segment? A. Or from a health related facility to a domicile related facility. To a lesser cost care.

Have you done any follow-up of either the number of patients transferred as a result of this utilization review or what has happened to those patients, how many of them ended up back in a hospital within X period of time and how many of them died?

Mr. Kay: Let's take one at a time.

A. As I indicated before, we receive statistics as far as how many patients go to certain levels of care. As far as how many times we are counting the same patient, I couldn't tell you.

Q. That is not to say that there aren't studies that exist, because the Health Systems agencies do perform certain studies like that to determine occupancy and certification of needs within a certain—

Q. But the Department hasn't followed up on any patients longitudinally, followed through to see how many

times the same patient was being transferred. Are we getting patients who are going back and forth, or is it one patient going once and staying there? A. With our data system, we will be able to [51] track a patient to see if he goes from the SNF to the HRF and back immediately because of some breakdown or if he goes to the HRF out of the system and again comes back. We would be able to determine that.

* * *

[53] By Mr. Gassel:

Q. Is it a reasonable assumption that there are a number of patients in the long-term care system who do not have either family or close friends who are looking after their affairs? A. No, that is not an accurate assumption that can be made, that people who go into nursing homes are necessarily abandoned.

Q. But it is true that there are probably a percentage of them?

Mr. Kay: Do you know?

A. I can't tell you if there are ten per cent, five per cent, one per cent. I would assume—

Mr. Kay: Don't assume.

Mr. Gassel: He is a health care professional. He can make assumptions along those lines.

Mr. Kay: If you can make an educated assumption.

Mr. Gassel: He does work in the field.

[54] A. It's an assumption that can be made just on the general population that you may not have any kin, may not have any close friends, so you can carry that proportion throughout any type of projection.

Q. Are the elderly less likely to have kin than you and I? A. I don't believe so.

Q. I mean, when people get old, they die off. A. Yes, but when people get old, they usually leave the ones that take care of them.

Mr. Kay: Off the record.

(Discussion off the record.)

Q. I am going to make an assumption—tell me if it is an invalid assumption—that there are a number of persons in long-term care facilities, probably a significant percentage, who are either senile or otherwise not capable of handling affairs like utilization review themselves, without assistance.

Is that an accurate assumption?

A. It would depend on what you are calling senile. If you are indicating that there is a certain percentage of individuals within the RHCF setting that have received some type of cerebral vascular accident or have arteriosclerotic heart disease that would [55] impair their capacity to understand, we do know that there are a number of patients that have had that as a diagnosis.

As far as whether or not they were cured of that particular diagnosis, I couldn't tell you.

Mr. Robert: Is there anything in the system to flag those types of people so if an adverse decision is made by the utilization review, the system can be assured that a representative is watching over the interests of that flagged type of person?

The Witness: We would not flag that type of patient with that diagnosis, because they are found throughout the system. The are found throughout society. We have found through our study that diagnosis does not predict an individual's level of

care. He may be at home with the same diagnosis that he would be in the hospital with. It depends on the intensity and the current nature of his diagnosis.

By Mr. Gassel:

Q. Is it true that there is no system which would identify and flag those individuals who lack mental or physical capacity and/or lack appropriate next of kin [56] or next friend to insure that somebody is looking out for their interest in the case of an adverse utilization review determination? A. Within our regulations, we require that in any type of admissions process there be identified those individuals who would be responsible or who would be contacted in cases of emergency.

If there is no one to handle an individual's financial or discharge planning, they should be contacting a local district.

Q. What kind? A. The local Social Services district.

Q. So they are supposed to take care of those needs? A. They are supposed to help those that are in need of some type of welfare.

Q. Do you know that in fact Social Service districts perform that function for patients in those facilities? A. I can say only through my own personal experience that yes, they do. Through the nursing home that I worked for, we had individuals who had as their conservator or as their legal guardian, the Commissioner of Social Services.

[57] Q. But you had experience in a facility. Isn't it true that only the smallest percentage, very few individuals, have either legal guardians or conservators? A. In my experience in our facility, I would not say it was an overwhelming percentage, but that's basically because the other patients would have had some type of representation through their family or friends.

* * *

[67] By Mr. Robert:

Q. Could you explain the difference between when you need the certification of two utilization review doctors as opposed to only one utilization review doctor? A. There is the case of whether a utilization review physician, upon reviewing the patient's medical condition as presented to him through the committee, decides that the individual needs an alternate level of care; that is, a level of care other than the one that they are currently placed in. And the individual's attending physician does not concur with the UR physician's [68] determination.

* * *

Q. Assuming that a personal physician says that his patient should remain at the facility and the utilization review doctor says he should not, what is the process of notification from the utilization to the personnel? A. You mean—

Q. The attending physician says, "My patient should stay." The utilization physician says, "No, you are wrong." A. There would be no notification until the second utilization review physician either concurred with the UR physician or the attending physician.

* * *

[69] By Mr. Gassel:

Q. Mr. Maddaloni, on this attending physician business, are the attending physicians always house staff or can they come from the outside? A. Yes, they can be private practicing physicians and do not have to be affiliated with the facility.

Q. Do a significant number of facilities in the State operate on that basis with outside staff? A. I couldn't give you an accurate reflection. We are trying to establish rates so that they include service of the physician within it.

That does not mean that they in turn cannot seek an alternate group of doctors to provide the service.

Q. Are you aware of the facilities that do not have in-house staff doctors? A. Oh, yes.

[70] Q. In those cases, the attending physician might come by just once a month or so, might only be in the nursing home once a month or twice a month or infrequently; is that correct? A. Under Federal and State regulations, the attending physician would have to see the patient at least monthly. And if he is going to see the individual less than every thirty days, he has to document in a plan of care the reason he is not seeing him more often.

Q. He has to be in the home at least that often, but it might also mean that he is not there on a day-to-day basis? A. That's correct.

Q. He might be there no more than once a month, twice a month, and see a number of patients that day; is that correct? A. That's correct. It would be dependent on his patient's condition.

Q. Is the attending physician required to attend the utilization review committeee meetings? A. No.

* * *

[94] Q. I would like to ask some questions about the PMR and IPR.

There is a Federal requirement that the state do something called utilization control as I understand it which is to supervise utilization review and monitor how it is conducted in the various facilities.

Is PMR and IPR the mechanism that the Department uses to perform that utilization control? A. That is part of the utilization control, yes.

Q. What else is there? A. There would be the DMS1 data system, when developed.

Q. That is in the future? A. Yes. The MMIS system, when developed. But currently, our best control on utilization is the PMR's and the surveys.

[95] Q. Do the surveys check on individual eligibility and individual placement? A. As far as medical reviews, no.

Q. So it is only the PMR and the IPR? A. That is correct.

Q. Do they fill out a form on each patient? A. No, they fill out a form which checks off a variety of medical information that has to be in the form. In other words, are the doctor's medical notes available and are they documented appropriately. It does not assess the patient as far as saying does this person ambulate, does he not ambulate.

It looks at the individual and the record as far as saying are the records and the plan of care being carried out, is the medical record appropriate to reflect the care needs of the individual.

Q. The utilization review evaluates patients against certain criteria which the State defines. Does the PMR and the IPR evaluate the patient individually and does it evaluate against the same criteria, namely, the DMS1 and the scoring system? A. It would not utilize them, because it has to actually give a full chart review and a one hundred percent patient review. It has to check each patient [96] to determine that there is appropriate care being provided to the patient and that his physical condition is not deteriorating in any way where his needs are not being met.

Q. And the PMR makes a medical evaluation of the patient's needs? A. That is correct.

Q. Against what criteria? A. Against Federal and State criteria.

Q. But the Federal and State criteria are defined in Memo 77-9 and 77-10, aren't they? A. It depends on the specific review. Now, we are talking about an over-all review. The criteria that is presented on the DMS1 form is not asking whether or not the nurse's notes are contained in the medical record. This is something that the PMR would be asking.

So it goes beyond just the DMS1, as I indicated. It asks for more than just what the regulations that are appropriate for DMS1 are concerned with.

It has incorporated the information that we would have on the DMS1, yes. That type of information is incorporated in the review.

It does not take the DMS1 form, to take the patient and review the DMS1 form. It takes another [97] form and determines whether or not the medical record and the patient are reflective of one another.

Q. Are the criteria for that form identical as for the DMS1? A. No. That's because they are serving another purpose. One is asking about the appropriateness of the medical record in its entirety and the quality of the care being provided to the individual. The other one is assessing the individual's condition.

Mr. Robert: If the PMR indicated that the medical record did not reflect in it the physical nature of the patient, what would the validity of the DMS1 be that scored itself from the medical records that have now been stated not to coincide with the actual medical needs of the patient?

The Witness: We would be making an assumption that the DMS1 was only based on the medical record. The DMS1 is part of the medical record and would therefore be in error as part of the

medical record if in fact the DMS1 did not reflect the patient's medical condition.

That is an assumption that would have to be made, since the DMS1 would be just assessment [98] by reviewing the patient's condition and making an observation of his condition without having to constantly refer to the chart.

Q. If one were to see a PMR report for two facilities identifying the same PMR team leader, can we assume that it is the same team or can one leader head two teams? A. Well, once again it's going to depend on the area office, how they structure themselves, how large they are. Certain team leaders have a number of different teams.

Well, it's one team, but a number of different reviewers, and they will go in as a team to one facility and may replace a nurse with another social worker and go into the other. So that the individuals are not the same, but they are under one team.

Q. Could one team leader be doing a PMR on two facilities simultaneously heading up two different teams; or is that not the way it works? A. Then they would be team coordinators, just coordinating the review.

Q. Does that happen? A. I couldn't state with any accuracy.

Q. On a PMR report, when it says date of [99] completion or something like that, is that the last date they were on site or could that be a date later? A. No, that is the last date they were on site. That's the date of the last chart review.

Q. So if one were to see an October 10th date that one PMR was completed and a second PMR was completed by the same team on October 15, would you assume that the second one was done between the 10th and the 15th? A.

No, it could be that there was another nurse and social worker or another group of reviewers in that particular facility at the same time another team was in another facility.

Q. So they were going on simultaneously? A. Yes, but there are two different entities here.

Q. But even if they were identified as the same team leader? A. Once again, it could be a team coordinator that you are identifying rather than a team leader and, in effect, you have got two review groups and one is in one facility and one is in another.

By Mr. Robert:

Q. What is the role of the local medical [100] director? A. The local medical director is either a state or county employee, depending on whether it's a contract county or whether the state is making the reviews. He is responsible for making determinations as to the appropriateness for paying Medicaid claims.

He will review anything from a physician's request for some type of orthopedic device or a placement of an individual in a particular facility.

Q. As to the UR process, can the local medical director reverse a UR decision? A. He will not reverse the decision. He would make a determination for Medicaid purposes that we would not pay, given the information that is available.

Q. If the utilization review decision was not to transfer a patient, could the local medical director make a decision not to pay that facility for that patient? A. Under our regulations, Social Services regulations, that would be the case.

Q. What criteria would the medical director use? A. He would be utilizing the same information. Or he has access to the same information that the UR Committee would; that is, the DMS1 form and any other pertinent in-

formation that would justify or support the [101] placement.

Q. So the utilization review team has the information before it and certifies that the patient should not be transferred. I assume that is then forwarded to the local medical director and he has the authority to not pay the Medicaid payment to that facility based on the UR decision? A. The local medical director is certifying patients. He is not necessarily stopping it, because it hasn't started yet.

A phsyician is required to certify that the standards, if below 180 or 60, to SNF and HRF respectively, do not adequately reflect the individual's placement needs.

The local medical director would then review that certification and any justification for that decision and make a determination as to whether or not he will implement the Medicaid payment process.

Q. Could you explain the distinction between a local medical director reversing a UR and a local medical director certifying that he will not certify Medicaid payments? A. For him to reverse the determination of the utilization review—well, I believe under Chapter 77, [102] he can actually reverse the determination. However, in the way we have structured our assessment system, he does not get involved in the UR functioning as a committee.

He only gets involved in the placement certification, not the continued stay. We take the continued stay assessment to be what the UR Committee determines.

He may ask for samples of certain reviews if he feels that there is a problem and he wants to review the continued need for medical payment.

Q. Are there any definitions or instructions in the entire series regarding the capability of adult home or domiciliary care facilities? Are there any definitions or descriptions of what the capabilities are? A. In what regulations?

Q. In any of the health memoranda. A. No, the domiciliary are not under UR monitoring or jurisdiction; they are under the Department of Social Services.

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[103] By Mr. Gassel:

Q. Is there a system of monitoring the medical [104] records, the quality and completeness of medical records, in a facility other than the PMR and IPR processes you describe earlier? I don't want to repeat it if it is as you described it. Is the way that the Department monitors the quality and completeness of medical records in a facility through IPR and PMR? A. That's right. And the surveillance process would also monitor the medical records.

March 5, 1979 Pretrial Order (Excerpts)

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

* * *

[Title omitted in printing.]

[Appearances omitted in printing.]

A. *Nature of Action and Proceedings*

This is a class action suit brought on behalf of all Medicaid-eligible residents of nursing facilities—skilled nursing facilities (SNF's) and health-related facilities (HRF's)—in the State of New York challenging on procedural and substantive grounds the validity, under the Fourteenth Amendment to the United States Constitution, Title XIX of the federal Social Security Act (42 U.S.C. § 1396 *et seq.*), applicable regulations of the United States Department of Health, Education and Welfare (HEW), and applicable laws of New York State, of the utilization review and fair hearing process administered by the New York State Departments of Social Services and Health, insofar as it causes patients to be transferred or discharged from their current facilities or level-of-care, or threatened with such transfer or discharge.

In January 1978 this Court certified this action as a class action and issued a preliminary injunction on behalf of the plaintiff class requiring the defendants or the state or local agency to provide every facility patient, following an adverse utilization review (UR) determination that the

patient no longer needs his current level-of-care, with (1) timely and adequate written notice of proposed agency action to adjust Medicaid benefits which is provided by the State or local agency, fully complies with the requirements of 45 C.F.R. § 205.10(a)(4)(i)(B), and includes a detailed written statement of the specific changed medical or other circumstances justifying the UR determination, and (2) with unencumbered access prior to and during the fair hearing to all relevant documents and medical records, including all such documents and records which are located at the nursing facility and which contain so-called "medically contraindicated" information. By decision issued January 16, 1979 the Second Circuit Court of Appeals affirmed that preliminary injunction, insofar as appealed from by defendants on the issues of the State or local agency's obligation to provide the notice and the patient's right of access to medically contraindicated information.

Earlier, on June 30, 1978, on plaintiff's motion for partial summary judgment, this Court granted a declaratory judgment, but not injunctive relief, that the Department of Health Hospital Memoranda establishing the numerical scoring system used in filling out the long-term care placement form DMS-1 are legally invalid for noncompliance with the rulemaking requirements of the New York State Administrative Procedure Act. 456 F. Supp. 653. Plaintiffs are now preparing for a final trial on the merits of their claims.

B. *Nature of Parties*

The plaintiffs are a class composed of all residents of skilled nursing and health related nursing facilities in New York State who are recipients of Medicaid benefits. The defendants are the Commissioner of the New York State Department of Social Services and the Commissioner

of the New York State Department of Health. The State Department of Social Services is the "single State agency" responsible for administering the Medicaid program in New York State and insuring full compliance with all the Federal requirements and rights set forth in Title XIX of the Social Security Act and implementing HEW regulations, and is particularly responsible for providing agency and fair hearing review of adverse UR determinations. The State Department of Health is responsible for licensing nursing facilities in New York State, for establishing reimbursement policies, for overseeing and reviewing patient placement, and for administering and monitoring the utilization review process for assessing the continued stay needs of facility patients.

C. *Jurisdiction*

As this Court has earlier determined, subject-matter jurisdiction over this suit is conferred upon the Court by 28 U.S.C. §§ 1331(a) and 1343(3).

D. *Relief Requested*

Plaintiffs seek a declaratory judgment that they have the following rights, with corresponding injunctive relief, requiring defendants, and their successors and agents, to secure those rights for plaintiffs:

I. There shall be no involuntary transfers of nursing facility patients in the State of New York, to a different level of care or facility, unless and until such time as defendants:

A. provide plaintiff with all the procedural and substantive safeguards which are set forth in II below and to which plaintiffs are entitled by the Constitution and federal and state law, *and*

B. with regard to patients who do not already reside in facilities providing at least skilled nursing and health related care, complete all steps necessary to minimize the impact of any involuntary transfer or threat thereof through alternative administrative systems which include, but are not limited to:

(i) maximizing the number of facilities that provide at least SNF and HRF levels-of-care by requiring all single-level SNF or HRF facilities capable of doing so to reclassify a portion of their beds to the other level of care, over a phase-in period; or

(ii) adopting an effectively equivalent system such as a single all-inclusive level-of-care, or

(iii) having beds whose classification can be shifted between "levels-of-care" depending on the needs of the occupant, or

(iv) a combination thereof; *and*

(v) modifying the present "alternate care" provisions (which currently require that a Medicaid patient requiring alternate care to accept the first available bed within 50 miles) to enable any patient who so desires to receive such alternate care within the same facility.

II. *Required Procedural and Substantive Safeguards*

A. Every patient who is the subject of an adverse UR decision must be provided, at defendants' expense, with a trained representative from the point of initial UR notice to the patient, and with counsel, also at defendants' expense, to represent him during the course of any hearing or other review proceedings requested to

appeal in adverse determinations, if such counsel is not otherwise available.

B. Following an adverse UR determination, the state or local Department of Social Services or Health must provide the affected patient with timely and adequate notice of proposed agency action to adjust Medicaid benefits that fully complies with the requirements of 45 C.F.R. § 205.10(a)(4)(ii)(B) and includes a detailed written statement of the specific changed medical conditions or other circumstances of the patient which purportedly justify the adverse UR determination.

C. Every affected patient must have a fully adequate opportunity, prior to and during the fair hearing, to review an adverse UR determination, to have unencumbered access to, and to review and copy without charge, the contents of that patient's case file, and all documents and records to be used against the patient at the hearing, all documents, medical or otherwise, which were considered or relied on by the Utilization Review Committee (URC), and all medical documents and records concerning the patient which are located at the nursing facility where the patient resides, including all so-called "medically contraindicated information" contained in any such documents or records.

D. The URC person(s) who make(s) the adverse determination must personally examine the affected patient, and must be present at the hearing and there present evidence sufficient to establish a *prima facie* case to sustain the correctness of that determination.

E. The *prima facie* showing which must be made at the fair hearing in order to affirm an adverse UR determination must be made by clear and convincing proof of the following elements:

1. that the patient will not suffer consequential

harm, either physical or psychological, as a result of, e.g., physical relocation, dislocation from home, unfamiliar environment, separation from others, erroneous level-of-care decision, placement in an inappropriate facility, etc.;

2. that the proposed level-of-care is appropriate;

3. that the specific proposed placement will meet the patient's needs;

4. that all procedural and technical prerequisites of the UR process have been complied with, including:

(a) that the following persons signed the DMS-1 or other assessment instrument, indicating their recommended decision and the reasons for it;

(i) the RN who completed the instrument;

(ii) the UR "screener" who screened the case and initially determined that continued stay is inappropriate;

(iii) the UR doctor who made the initial UR finding;

(iv) the patient's attending physician to indicate that he has seen the initial finding and has had the opportunity to review it;

(v) two UR doctors who reviewed the attending physician's recommendation, if the latter presented additional or clarifying information concerning the need for continued stay or contested the adverse initial UR finding;

(b) that the UR physician(s) who made the determination examined the patient and made a notation that such examination was made;

(c) that the URC has considered in its initial review the reasons and plan for continued stay if the attending physician believes continued stay is necessary;

(d) that a transfer plan identifying and describing the specific proposed transferee facility or location appropriate to the patient's medical and psycho-social needs was developed prior to each adverse UR determination, was considered by the URC and was incorporated in its determination;

(e) that, in the case of a patient initially admitted to the facility prior to March 1, 1977 (regardless of intermittent hospitalization or other short-term absence), the assessment instrument was not scored and the numerical criteria were not applied;

(f) that the DMS-1 form contains no unrefuted answers to the non-numerically weighted questions on the DMS-1 form (e.g., Question 3D, 3E, 3F, 9A-C, 10), which would be inconsistent with the recommended determination;

(g) that the review process and assessment instruments used considered and assessed all relevant psycho-social factors;

(h) in the case of a transfer to a level-of-care below that of HRF, that the patient requires no care or services beyond room and board;

(i) that all procedural requirements specified in paragraphs A-C above have been satisfied.

F. No adverse UR determination may be made or implemented which would not meet the requirements of a *prima facie* case described in paragraph E above.

G. The defendants may not render a fair hearing decision affirming an adverse UR determination. Unless a transcript and all exhibits are reviewed and adequately considered by the reviewing agent, and further, the reversal of a favorable recommendation of the hearing officer cannot be based on consideration of a credibity issue.

H. The state or local agency must independently review and reject adverse UR determinations for at least facial defects (including, but not limited to, items identified in paragraphs E(4)(a), E(4)(b), E(4)(e), E(4)(f), and E(4)(i), above) and for defects in the statement of reasons included in paragraph B above, and must so certify, before agency notice may be sent to the patient.

I. Doctors who serve on the UR committee of a facility may not also be the attending physician for any patients in the faciltiy or in any other facility owned or operated under the same management, ownership or auspices.

J. The right to a prior hearing incorporating the above procedural safeguards shall be guaranteed as well in cases of a proposed transfer arising from a determination.

(a) by the URC that the patient should be transferred to a higher level of care; or

(b) by the facility or its agents.

K. All state regulations, standards, and procedures governing the utilization review and fair hearing processes for determining the appropriate level of care for a nursing facility patient shall be promulgated in accordance with the State Administrative Procedure Act, and further shall conform in all respects with applicable federal statutory and regulatory provisions.

E. *Factual Issues Underlying Plaintiff's Claims for Relief*

Plaintiffs—Generally

1. Whether a substantial proportion of the plaintiff class is elderly, infirm, frail, dependent, confused, or has a poor prognosis, or a combination thereof.

2. Whether a substantial proportion of plaintiffs are essentially helpless because of physical or mental impairment.

3. Whether, as a practical matter, the overwhelming majority of plaintiffs are confined to nursing homes without choice, for want of a viable alternative.

Defendants' System of Utilization Review and Fair Hearing Appeals—Generally

4. Whether defendants' DMS-1 form and numerical scoring system are inadequate *per se* and/or as employed in the utilization review process.

5. Whether defendants' utilization review procedures are inadequate *per se* and/or as carried out in SNF's and HRF's in New York State.

6. Whether defendants' system of notice and fair hearing review of decisions which recommend transfer of nursing home patients to other facilities or other levels of care, is inadequate *per se* and/or as applied.

7. Whether defendants have failed to correct the inadequacies, both inherent and as implemented in the DMS-1 form and numerical scoring system, utilization review procedures, and system of notice and fair hearing review.

8. Whether, and to what extent, in the context of defendants' present system of nursing home classification and reimbursement, defendants' DMS-1/UR system:

(a) causes harm or risk of harm to Medicaid patients in SNF's and HRF's flowing from:

(i) anxiety or trauma

(ii) deprivation of care or services

(iii) eviction from place of residence or other dislocation from environment

(v) [iv] interference with relationships with friends, family, staff or others

(b) actually serves legitimate interests of defendants.

9. Whether the harm to plaintiffs outweighs the interests of defendants actually served by the present system.

10. The extent to which alternatives and/or modifications are possible which defendants have failed to implement which:

(a) would be less restrictive and harmful to plaintiffs than the present system

(b) would serve defendants' interests no less well than the present system.

11. Whether defendants have adequately or effectively controlled the functioning of the UR and fair hearing process.

12. Whether defendants have provided sufficient safeguards to assure that eligibility is determined and care provided in a manner which is consistent with (a) simplicity of administration and/or (b) the best interests of plaintiffs.

13. Whether defendants' present system of UR and fair hearings, in conjunction with defendants' present system of nursing home facilities and reimbursement, operates in a manner consistent with . . . simplicity of administration and/or the best interests of plaintiffs.

14. Whether it is possible to effectively balance the protectable interests of plaintiffs and defendants without:

(a) halting the involuntary transfer of nursing home patients to other facilities or levels of care, and

(b) implementing the procedural and substantive safeguards outlined in DII above, to the extent involuntary transfer is permitted at all, and

(c) modifying the level-of-care classification and/or method of Medicaid reimbursement as outlined in DI above, to the extent that patients residing in, single level facilities are threatened with involuntary transfer.

Notice

15. To the extent that the issue of whether notification of due process rights must be provided by the state or local agency or may be delegated to the facility, is not purely a matter of law, whether

(a) the notification procedures required by the preliminary injunction are unduly cumbersome, inefficient or confusing,

(b) a notification system which relies on facilities would adequately protect patients or be dependable,

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Representative and Counsel

16. Whether a substantial proportion of plaintiffs' are unable to protect their rights and interests upon receipt of an adverse UR determination.

17. Whether a substantial proportion of those persons have no one to reliably protect those interests.

18. Whether defendants have an effective means of

(a) identifying who such persons are, and

(b) insuring that their interests are reasonably protected by appropriate advocacy assistance and, when necessary, legal counsel.

Reliability of UR and Fair Hearing Decisions

19. To what extent UR determinations and fair hearing decisions are unreliable and prove to error if the UR committee person(s) who make(s) the adverse determination did not personally examine the patient affected and present evidence at the hearing, if one is requested, sufficient to substantiate the determination.

20. To what extent UR determinations and fair hearing decisions are unreliable and prove to error without a showing by clear and convincing evidence that:

(a) the patient will not suffer consequential harm;

(b) the specific characteristics of the proposed placement, or, if necessary, the specific facility, were identified and will be appropriate to the patient's specific needs.

21. To what extent fair hearing decisions are unreliable and prove error if rendered without preparation of a

transcript of the hearing which is reviewed along with the exhibits, or if hearing officer recommendations favorable to the patient are reversed on issues of credibility.

22. To what extent UR determinations and fair hearing decisions are unreliable and prove to error if the state or local agency does not review and reject adverse UR determinations for at least facial defects before agency notice is sent to the patient.

23. To what extent UR determinations and fair hearing decisions are unreliable and prove to error if UR committee physicians also serve as attending physicians in the facility or one under the same management, ownership or auspices.

Attending Physicians

24. Whether patients attending physicians are afforded a meaningful and adequate opportunity to respond to the initial UR finding.

Specificity of Destination

25. Whether individual facilities have such unique characteristics and individual differences that a decision to involuntarily transfer a patient, which identifies the recommended destination only by its level-of-care, is inadequate.

Procedural and Technical Pre-requisites

26. Whether the procedural and technical pre-requisites of the UR and fair hearing processes are not complied with in a substantial proportion of cases and the fact of non-compliance is not detected or cured by the UR determination or fair hearing decision.

Local Agency Review

27. Whether the state or local agency adequately reviews and rejects adverse UR determinations for at least facial defects before notice is sent to the patient.

Non-UR Transfers And Tranfers To Higher Level

28. Whether, and to what extent, a prior fair hearing incorporating all procedural safeguards is useful in protecting patients in SNF's and HRF's from erroneous, arbitrary, punitive or retaliatory discharge, in cases of proposed transfer arising from a determination by

(a) the UR committee that the patient should be transferred to a higher level of care, or

(b) the facility or attending physician.

State Admin. Proc. Act and Supremacy Clause

29. Whether defendants' UR and fair hearing regulations, standards and procedures are properly promulgated in accordance with the New York State Administrative Procedure Act and the Supremacy Clause of the United States Constitution.

F. *Legal Issues Underlying Plaintiffs' Claims for Relief*

I. *No Involuntary Transfers*

Whether all involuntary transfers of nursing facility patients to other facilities or levels-of-care must be stopped (1) as the least restrictive alternative to the unwarranted and severe intrusion of the present system

upon the patients' constitutionally fundamental rights under the Fourteenth Amendment to procedural due process and to protection from harm and (2) in conformity with the requirement under the Social Security Act and the HEW regulations that the defendants maintain an effective system of utilization review, effectively monitor and control the operations of that system and administer the Medicaid program in the best interests of the patients consistent with considerations of simplicity of administration.

II.A *Right to Assigned Representative and Legal Counsel*

Whether the affected patient has the right under the Fourteenth Amendment's Due Process Clause to the provision of such representative and counsel at state expense, flowing from the heightened judicial solicitude to which plaintiff's class is entitled and the constitutionally protected patient interest in protection from harm and loss of life which is at stake, along with the Medicaid benefits and necessary medical care and services.

II.B *Notice Requirements*

Whether the provision of such notice by the State or local agency is required by HEW regulations and the Fourteenth Amendment's Due Process Clause, as earlier found by this Court and the Second Circuit in this case.

II.C *Pre-Hearing Access to Records*

Whether such patient access to all records and documents is required by HEW regulations and the Fourteenth Amendment's Due Process Clause, as earlier found by this Court and the Second Circuit in this case.

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II.D *UR Doctor Examination of Patient and Presence at Hearing*

Whether HEW regulations, regulations of the New York State Commissioner of Social Services, principles of federal and New York State administrative law, and the Fourteenth Amendment's Due Process Clause require that the person who made the adverse UR decision affecting: (1) the patient's Medicaid benefits, (2) level of medical care and services, and (3) constitutional right to protection from harm must appear at the review hearing and present competent and reliable non-hearsay evidence sufficient to establish a *prima facie* case in support of that decision.

II.E *Prima Facie Case at Hearing*

Whether the initial decision-maker's *prima facie* case at the fair hearing in support of an adverse UR determination must include proof of the essential procedural and substantive requisites of a properly rendered UR determination under HEW regulations, the Constitution, and defendant's own procedures; and whether such proof must be by clear and convincing evidence, in light of (1) the fundamental constitutional interests at stake, (2) the probability of error, (3) the harm flowing from error, and (4) the heightened judicial solicitude to which members of plaintiffs' class are entitled.

II.F *All Adverse UR Determinations Must Meet Prima Facie Requirements*

Whether the Fourteenth Amendment's Due Process Clause, the Social Security Act, and New York State law permit an adverse UR determination to be made or implemented which could not, as a matter of law, establish a *prima facie* case at the fair hearing so as to justify

action based on that determination to transfer the patient and adjust his Medicaid benefits.

II.G *Review of Fair Hearing Transcript*

Whether the Fourteenth Amendment's Due Process Clause and New York State decisional law require the defendants to review and consider the transcript and exhibits of the hearing before rendering a fair hearing decision adverse to the patient and prohibit defendants from reversing a hearing officer recommended decision favorable to the patient on the basis of credibility issues.

II.H *Independent Agency Review*

Whether such State or local agency review before sending notice of intended agency action to adjust a patient's Medicaid benefits is required by the Fourteenth Amendment's Due Process Clause, the Social Security Act, HEW regulations, and New York State statutory and regulatory law.

II.I *Impartiality of UR Doctors*

Whether the inherent bias in favor of the facility's interest arising from the fact that the UR doctor is the attending physician for any patients in the same or a similarly controlled facility violates the substance or intent of the federal statutory and regulatory provisions regarding UR doctor impartiality and the Fourteenth Amendment's Due Process Clause.

II.J *Right to Prior Hearing in Cases of Facility-Initiated Transfers and UR Transfers to Higher Levels of Care*

Whether the patient has the right to an evidentiary hearing prior to such transfers, under New York State

regulatory and decisional law and the Fourteenth Amendment's Due Process Clause; whether the procedural protections of due process are triggered for such transfers by the existence (a) of state action inhering in the requirements of the Social Security Act, Hew regulations, and New York State law that defendants review these transfer decisions, in the extensive state regulation of the URC and the facility and the "symbiotic relationship" between the State and the URC and facility, and in the "state" or "public function" performed by the URC and facility; and (b) of the deprivation of patient interests protected by due process in the ultimate reduction of Medicaid benefits (transfer down), in the attendant transfer trauma and deprivation of the patient's constitutional right to protection from harm, and in the patient's right under HEW regulations to be free of a facility-initiated transfer except for limited, specific reasons.

II.K *Proper Promulgation and Content State Regulations and Procedures*

Whether all such regulations, standards, and procedures must be promulgated in accordance with the New York State Administrative Procedure Act, under the terms of the Act, New York State decisional law, and the earlier decision of this Court (456 F. Supp. 653), and must conform to federal law under the Supremacy Clause of the United States Constitution.

G. *Joint Statement of Facts*

The following is the parties' joint statement of facts. Statements of fact not otherwise identified have been stipulated as true by the parties. Plaintiffs' and defendants' respective versions of disputed facts are indented from the margin and identified in each case by the words *"Plaintiffs assert"* or *"Defendants assert"*.

Pretrial Order

I. *Nursing Home Patients And the Long Term Care System in New York—Generally*

1. Under New York law, nursing homes are known as Residential Health Care Facilities (RHCF's).

2. There are two levels of nursing home care: skilled nursing facility care ("SNF") and health related facility care ("HRF"). Under federal law and regulations HRF's are referred to as Intermediate Care Facilities ("ICF's").

3. SNF's and HRF's are licensed by the Department of Health and receive reimbursement under the Medicaid program.

4. There are approximately 95,000 nursing home beds in the State of New York, including approximately 68,000 SNF beds (70%) and 27,000—30,000 HRF beds (30%).

5. There are approximately 611 nursing homes in New York State, including approximately 291 single level SNF's (48%), 290 combination SNF-HRF (48%), and 30 single level HRF's (5%).

6. In addition to SNF's and HRF's (nursing homes), there is a system of adult homes (which are *not* nursing homes) in New York known as Residential Care Facilities for Adults ("RCFA's") or Domiciliary Care Facilities ("DCF's"). This is a placement level below the HRF level.

7. DCF's are licensed by the Department of Division of Adult Residential Care (DARC) of the Department of Social Services and receive reimbursement under the Supplemental Security Income (SSI) program.

8. DCF's are not medical facilities; they are not permitted to provide medical or nursing services, may not hire nurses

for the purpose of providing nursing services; and may not admit or retain a person in need of continuous nursing care. In some adult homes catering to SSI (Medicaid) recipients, mental hospital dischargees and alcoholics are mixed in with elderly residents.

9. *Defendants assert* that (a) a DCF resident could be in need of intermittent or occasional nursing service which could be provided by visiting nurse service or like provider. (b) it is possible for a DCF operator to have persons with nursing credentials on staff; some do.

10. More than 90% of patients in SNF's and HRF's in New York State receive Medicaid benefits for the cost of their care.

11. When a patient is transferred from an SNF or HRF to another facility or another level of care, his/her Medicaid reimbursement rate is adjusted accordingly.

12. Medicaid reimbursement rates ordinarily are lower for HRFs than for SNFs and lower for DCFs than for either HRFs or SNFs. Accordingly when a patient is transferred to a lower level of care, there is a reduction in the patient's Medicaid reimbursement level.

13. *Plaintiffs assert that:*

(a) a substantial proportion of patients in SNF's and HRF's are elderly, infirm, frail, dependent or confused or have a poor prognosis or a combination thereof,

(b) a substantial proportion of patients are essentially helpless by virtue of a physical or mental impairment,

(c) for practical purposes, most patients are confined to nursing homes without choice, for want of a viable option.

14. *Defendants assert that:*

(a) There is a shortage of SNF and HRF beds in the State of New York. This shortage results in individuals who need SNF or HRF care actually not receiving either. Some of these individuals are in hospitals while others are in the community.

(b) This shortage is expected to persist into the near future.

(c) The projected shortage assumes a properly functioning utilization review (UR) process. If UR transfers are stopped, the shortage of beds will increase.

II. *Description of Defendants' System of Utilization Review*

15. Defendants have established a system of Utilization Review (UR) in nursing homes in New York State, pursuant to federal law and regulations, under which all patients in SNF's and HRF's are required to be periodically reviewed to determine if they remain eligible for the level of care they are receiving.

16. Defendants' policy is that UR applies only to Medicaid patients.

17. The Department of Health promulgated a long term care placement form, known as Form DMS-1 (Plaintiff's Exhibit 1).

18. Effective March 1, 1977, the Department promulgated a numerical scoring system for the DMS-1 form under which numerical points are assigned to certain items on the DMS-1 form (Plaintiffs' Exhibit 2) to determine the patients' "predictor score". The "predictor score" cut-off for SNF is 180 points and above; the cut-off for HRF is 60 points and above.

19. Questions 3D and 3E on the DMS-1 form ask whether the patient needs skilled nursing care; they document the need for skilled care.

20. The DMS-1 and numerical system are supposed to be used by the UR committee in each nursing home in assessing each Medicaid patient's need for continued stay.

21. For patients admitted to the facility prior to March 1, 1977, the DMS-1 form is supposed to be completed but the numerical standards and score are not supposed to be applied. The reason for this is defendants' fear that application of the numerical standards might bias the decision of the UR committee.

22. SNF patients are subject to UR following admission, at least once every 30 days for the first 90 days after admission, and at least once every 90 days thereafter.

23. HRF patients are subject to UR at least once every 6 months.

24. For purposes of UR, the DMS-1 is filled out by a registered nurse. This "nurse-assessor" is usually an employee of the facility.

25. The nurse who fills out the DMS-1 form ordinarily does not examine the patient.

26. *Defendants assert* that the nurse who fills out the DMS-1 is often a nurse with direct or supervisory responsibility for the patient. Accordingly, the nurse has first-hand knowledge of the patient's condition and is not dependent on the patient's records.

27. In some nursing homes, a special nurse, who is not involved in patient care, and who does not have personal knowledge of the patients, is hired to complete the DMS-1 forms.

28. *Defendants assert* that the special nurse may rely on other individuals with personal knowledge of the patient.

29. Defendants' policy regarding review of cases by the UR committee, following completion of the DMS-1 form, is as follows:

(a) cases are initially screened by a "screener", (who may be the same person as the "nurse assessor"), a non-physician member of the UR committee who need not be a nurse.

(b) if the "screener" determines that the case meets the criteria for continued stay, the patient is approved and the case is not referred to the physician member(s) of the committee; an SNF patient who receives more than 180 points or an HRF patient who receives more than 60 points is automatically approved.

(c) cases in which it appears to the "screener" that the patient no longer requires the current level of care and/or does not meet the DMS-1 criteria and numerical standards (i.e, less than 180 points for an SNF patient, less than 60 points for an HRF patient) are supposed to be referred to the physician member(s) of the committee.

(d) ordinarily the review is conducted by one physician member of the UR committee.

(e) the physician does not personally examine the patient but is supposed to review the DMS-1 form, any accompanying documents and any other information he thinks necessary. He may consult with other non-voting members of the UR committee, such as the social worker.

(f) the UR physician then decides whether continued stay is necessary. In doing so, he may consider psycho-social factors. After making his initial finding he must indicate and certify the patients' level of care needs on the back of the DMS-1 form.

(g) if the initial finding is that continued stay is not necessary, he is supposed to notify the patient's attending physician within 1 working day of this finding.

(h) the attending physician has 2 working days from the notification date to respond. If attending physician fails to respond, the decision of the UR physician is final. If the attending physician disagrees, the decision requires the concurrence and certification by a second UR physician.

30. The UR committee is supposed to be established by the facility and to consist of two or more physicians and other personnel selected and appointed by the facility. The physician members are reimbursed for their services by Medicaid.

31. Utilization review physicians are not supposed to be attending physicians of the patient being reviewed, but may be attending physicians for other patients in the same facility.

32. It is the defendants' policy that a staff physician of a facility cannot be a UR physician for that facility. However, under defendants' policy an attending physician who receives a substantial part of his income from attending to patients in a facility, may be the utilization review physician for persons who are not his patients at that facility.

33. Relevant psychosocial or other supplemental information is supposed to be considered by the UR committee

and may be added or attached to the DMS-1 form, although ordinarily such information is not added or attached to DMS-1 forms.

34. *Plaintiffs assert* that:

(a) ordinarily the utilization review physician does not consult with the non-voting members of the utilization review committee prior to making a utilization review determination.

(b) defendants do not know whether, or to what extent, utilization review committees actually take psycho-social factors into account in making their determinations.

(c) many UR committees use the numerical point system as the sole or predominant factor of placement and fail to consider relevant psycho-social factors.

35. *Defendants assert* that implicit in the URCs function to determine whether a particular individual can be transferred to a lower level of care, is the requirement to consider psycho-social factors which might impact on that determination.

36. The patients' "attending physicians" in a number of facilities are not staff physicians ordinarily on the premises, but are outside physicians who may be on the premises only infrequently.

37. Ordinarily, "attending physicians" do not attend UR committee meetings.

38. Ordinarily "attending physicians" find out about an initial adverse UR finding, if at all, in writing, by mail.

39. Defendants do not know the extent to which attending physicians receive information about initial UR findings or

final UR determinations or, if so, the extent to which they respond to this information.

40. *Plaintiffs assert* that patients' attending physicians are often not afforded a meaningful or adequate opportunity to respond to a preliminary UR finding.

41. Most adverse UR determinations, recommend relocation from one type of long term care institution (SNF, HRF, DCF) to another; few involve discharges to the community, to which patients ordinarily desire to return if they can.

42. Ordinarily, the Utilization Review Committee makes a recommendation regarding the level of care that the patient purportedly requires.

43. Ordinarily, the utilization review committee's recommendation specifies only the level of care and is not more specific regarding such matters as geographic placement location, particular facility characteristics, or specific facility or facilities.

44. Ordinarily, questions such as geographic placement location, particular facility characteristics, or specific facility or facilities are not decided by the committee but are decided afterwards in planning the discharge recommended by the committee.

45. *Plaintiffs assert* that within the particular level-of-care designation—SNF, HRF and DCF (adult home)—there is a substantial amount of variability between individual facilities in their ability to provide care and services for persons with varying degrees of need. A facility's level-of-care, as opposed to its individual characteristics, cannot be relied on as a basis for determining whether the facility is an appropriate placement in a particular case.

46. *Defendants assert* that UR committees can place limits or conditions on proposed transfers. For example, where appropriate, the transfer could be limited to within a multi-level facility. Limitations can be based on psychosocial factors.

47. There is no written documentation or training material for UR doctors, attending physicians, nurses, or UR screeners, describing or defining adult homes.

47. *Plaintiffs assert that:*

(a) SNF and HRF patients, whose DMS-1 forms reflect needs and disabilities which cannot be met in an adult home are nonetheless recommended by UR committees for transfer to adult homes.

(b) A large number of SNF and HRF patients, whose DMS-1 forms reflect needs and disabilities might be met in some adult homes but not others, are nonetheless recommended by UR committees for transfer to adult homes.

(c) The Division of Adult Residential Care of the Department of Social Services (DARC) does not specifically know which adult homes can or cannot meet the needs of such patients.

49. *Defendants assert that:*

DCF's may not accept or retain persons who require the following services or exhibit the following conditions:

(1) chronic, unmanaged incontinence, including use of catheters or colostomies that are not self managed;

(2) chronically bedfast, chairfast and unable to transfer;

(3) suffering from such a degree of mental illness and/or habituation or addiction to alcohol or other drugs such that the individual is causing or may cause

danger to himself or others or interferes with the care and comfort of other residents;

(4) incapable of self administration of required medication;

(5) in need of skilled observation of symptoms and reactions and the accurate recording of facts for purposes of reporting to the resident's physician;

(6) who is in need of a higher level of medical, mental health, or nursing care that can be rendered safely and effectively by approved community resources;

(7) in need of a medical, religious, cultural or dietary regimen that cannot or will not be met at the facility;

(8) suffering from a communicable or other disease of sufficient seriousness to constitute a potential danger to other residents and staff;

(9) in continual need of inhalation therapy treatments requiring use of oxygen or other explosive gases.

49a. *Defendants assert* that DARC has inspected all of the DCFs under its supervision. As of December 1978, 64% are in compliance, i.e., capable of providing service to persons in need of non-medical care and supervision. The remaining 36% have known violations and the process of correction and/or sanction is underway.

49b. The procedure and standards for UR in New York State are set forth in 10 NYCRR Part 400; 18 NYCRR § 505.9; 505.20, Department of Health Hospital Memoranda 77-9, 77-10, 77-13, 77-60, 77-74.

49c. In addition, defendants issued alleged "clarifying" instructions, Health Facilities Memo 78-39 and Social Services Directive 78-ADM-31, (Plaintiffs Exhibit 9) in the

summer of 1978, prompted by the pending lawsuit (*Yaretsky* v. *Blum*) and by certain task force meetings in New York and Albany.

49d. Health Facility Memorandum 78-39 contains the only explicit reference to consideration of "psychosocial factors" in making UR determinations, in defendants' regulations, memoranda and other promulgated materials.

49e. *Plaintiffs assert* that the manner in which the UR system is implemented was not significantly altered by the issuance of HFM 78-39 and 78 ADM-31.

III. *Notice of Adverse Determinations*

50. Defendants require that written notice, signed by the facility administrator, of the final UR determination that a patient can be transferred to a lower level of care, be sent to the patient, the patient's next of kin, attending physician and sponsor, within 3 days of the adverse UR determination.

51. The form of the notice that the facility is required to send following a UR determination which recommends transfer to a lower level of care, is Plaintiffs' Exhibit 20.

52. A decision, subsequent to an adverse UR determination, to reduce or terminate a patient/recipient's medical assistance or care, entitles the patient/recipient to notice a prior hearing and certain procedural rights (42 USC § 1396(a)(3), 45 CRF § 205.10):

> (a) a timely and adequate written notice must be sent to the recipient and his representative and that the notice must include:
>
> (1) [i] a statement of the proposed action;
>
> (ii) the specific regulations supporting such action;
>
> (iii) a full explanation of the individual's right to request a fair hearing, including the right of

unencumbered access to the recipient's case records and medical files as described in subparagraph (b) below;

(iv) the specific reasons for the intended action in the form of a written statement setting forth in specific detail the changed medical conditions which is signed by the utilization review physician who made the adverse determination;

(v) a copy of the adverse DMS-1.

(b) an adequate opportunity must be provided to the recipient and/or his representative to have reasonable access to examine before the fair hearing, the contents of the recipient's case file and facility medical records, as well as any other documents used by the utilization review committee in making its adverse determination and all documents and records to be used against the individual at the fair hearing.

53. The form of the notice which must be sent in such cases is Plaintiffs Exhibit 21.

54. *Plaintiffs assert* that:

(a) The required notice must be sent by the state or local agency and may not be delegated to the facility or UR committee.

(b) The notification procedures required by the preliminary injunction are not cumbersome to administer, inefficient or confusing to the patient.

(c) Abandoning direct local agency intervention and supervision in connection with notifying patients of their due process rights following an adverse UR determination, and relying instead for this task on facilities, would not benefit the patient or help streamline procedures.

(d) Past experience with relying on facilities or UR committees to provide such notification, indicates that such a system is not reliable as compared to the experience when the local agency sends this notice.

(e) Any slight administrative inconvenience is justified by the degree of additional protection afforded to patients when the local agency is required to send the notice.

(f) The right of access to records includes "medically contraindicated" information.

55. *Defendants assert* that:

(a) The required notice may be sent by the UR committee or the facility.

(b) Requiring the local social services agency to send the notice of adverse UR determinations creates a significant administrative burden and to the extent such requirement delays transfers, it effectively denies nursing home care to individuals who need it but presently are not receiving it. There are adequate alternative ways to make sure that patients receive the notices.

(c) The recipient is not permitted to have access to information which his doctor has stated, in writing, it would be medically contraindicated to disclose; although it does not limit the right of the recipient's representative to the information.

IV. *Policy Regarding Hearings For UR Recommended Transfers To Higher Level And Non-UR Related Transfers*

56. Since approximately July, 1978, it is defendant's policy that URC determinations which recommend a higher level of care are advisory opinions and not mandatory determinations. Medicaid payments will not be terminated if a patient refuses to comply with a URC recommendation that a higher level of care is needed.

57. It is currently defendants' policy that patients are not entitled to a hearing to review such determinations although a notice of determination is supposed to be sent.

58. *Plaintiffs assert* that:

(a) Defendants' practice prior to approximately November, 1978 was that patients who received an adverse UR determination recommending transfer to a higher level of care would receive a prior "fair hearing" to challenge the termination and that

(b) During the period that such hearings were granted, a significant number of such decisions were reversed on the merits.

59. *Defendants assert* that:

(a) It was defendants' practice prior to approximately July, 1978, that patients who received an adverse UR determination recommending transfer to a higher level of care could receive prior "fair hearings" to challenge the determination.

(b) During the period that such hearings were granted, there were approximately 10 hearings with approximately 5 of such decisions reversed on the merits.

(c) During the period July-September, 1978 defendants did inadvertently render a few decisions on the merits. Since September, the defendants have not rendered decisions on the merits where the URC recommended a higher level of care.

60. It is defendant's policy that patients recommended for transfer to another level of care by the facility, its agents or the patient's attending physician, do not have a right to prior notice and hearing to review such determination, although the patient may request that the

decision be reviewed by the URC and, upon such review, are entitled to the procedural rights described in paragraph 52 above. Defendants are presently reviewing this policy and may stop such reviews.

61. *Plaintiffs assert* that a substantial proportion of URC recommendations for transfer to a higher level of care and transfers recommended by the facility, its agent or the attending physician, are not proper under applicable federal and state regulatory prohibitions against arbitrary discharge.

V. *Representation And Counsel*

62. The statement in response to Question 15 of Health Facilities Memo 78-39 (Plaintiffs Exhibit 9) constitutes defendant's policy regarding the problem of representation of incompetent or confused patients.

63. *Plaintiffs assert* that:

(a) There are a substantial number of patients who are unable to cope with the utilization review procedures by themselves and who have no relatives or none who are interested or able to assist them in this area.

(b) There is no present system to identify patients who are unable to protect their interests upon receipt of an adverse UR determination, and are in need of legal advocacy assistance.

(c) There is no present system to provide legal advocacy assistance in all such cases.

(d) The due process rights of patients who do not have active family or other support system are rarely exercised.

64. *Defendants assert* that:

(a) Individuals are presumed competent.

(b) Facility social workers have the responsibility to identify patients who may need assistance in responding to URC recommendations that the patient be transferred to a lower level of care. The social worker can request fair hearings for such patients. The hearing officer is required to be especially protective of the rights of such patients.

VI. *Fair Hearing Procedures*

65. Approximately 50 fair hearings challenging adverse utilization review determinations are held in a normal month.

66. Those fair hearings are ordinarily held in the patient/recipient's nursing home.

67. The UR physician(s) who made the adverse determination is not required to, and ordinarily does not, attend the hearing.

68. The hearing officers who conduct utilization review hearings have received no special training specifically relating to: (a) utilization review; (b) conducting UR hearings; or (c) making recommendations in UR cases.

69. *Defendants assert* that while hearing officers have no special training sessions for UR hearings, they do receive formal training for their general function of recommending factual findings.

70. The hearing officers who conduct these hearings:

(a) have not been supplied with a copy of 42 CFR 400 *et seq.;*

(b) do not have specific knowledge of the DMS-1 scoring system;

(c) decide what weight, if any, should be given to DMS-1 questions 3d, 3e and 3f on a case-by-case basis;

(d) are not informed, unless they specifically request, whether their recommendations are affirmed or reversed or the reasons why.

71. Following the hearing, the hearing officer ordinarily makes a recommendation which, along with the record, is sent to the Albany office of the Department of Social Services.

72. Phillip Nostramo, senior attorney with the Fair Hearings Bureau of the Department of Social Services, reviews all long-term care fair hearings cases sent up by the hearing officers.

73. At the Albany office of the Department of Social Services, the hearing officer's recommendation and fair hearing file is reviewed, a decision is made, and the decision is adopted by the Commissioner of the Department of Social Services or her designee.

74. The person(s) who review the UR fair hearing cases does not listen to a tape of the hearing nor is a transcript made of the testimony prior to the decision.

75. Defendants' policy with regard to affirming or reversing UR determinations after fair hearing is as follows:

(a) a DMS-1 form plus a statement of specific reasons signed by the UR physician are sufficient to establish a *prima facie* case affirming the UR determination;

(b) a representative of the local agency, or the UR committee, or the facility or other person, is not required to appear at the hearing;

(c) hearsay alone may be sufficient to support the determination;

(d) assuming a *prima facie* case as described in subparagraph (a) is made, a DMS-1 form is not dis-

qualified from serving as the basis for a decision affirming the UR determination solely by virtue of the fact that:

(1) it is not signed by the nurse who completed the form and/or the UR "screener" and/or the UR physician; and/or

(2) it does not indicate their recommended placement; and/or

(3) a numerical score is contained on the form although the patient was a "grandfathered" patient admitted to the facility prior to March 1, 1977; and/or

(4) DMS-1 Questions 3D-F, 9A-C, 10 or 11 are answered in a manner which is facially inconsistent with the recommended decision;

(e) a UR recommendation may be affirmed notwithstanding lack of evidence in the record that:

(1) the written notifications were provided per Health Facility Memorandum 78-8 and 78 ADM-1 (per the preliminary injunction);

(2) the written notification contained the address and/or phone number of available legal services or other advocate;

(3) the patient and/or his representative were provided with access to the patients' files and records per HFM 78-8 and 78 ADM-1 (i.e., per the preliminary injunction);

(4) the patient's attending physician was notified of the initial adverse UR finding and/or received the notice and/or had an opportunity to comment;

(f) no formal "burden of proof" standard (e.g., substantial evidence, preponderance, clear and convinc-

ing) has been applied heretofore in rendering fair hearing recommendations or decisions; henceforth, defendants' policy is that the standard is "substantial evidence".

76. *Defendants assert* that:

(a) The Department first reviews the file to determine whether the proper documentation is in the file, then reviews the evidence to see whether the UR committee's case has been rebutted, and, as a practical matter, generally decides matters on a preponderance of evidence standard.

(b) While hearsay alone is sufficient to support a URC determination, the medical records constitute legally admissible and competent evidence.

(c) The record indicates that the final UR determinations was sent to the attending physician and that if the attending physician subsequently sends in comments objecting to the transfer, the matter will be remanded to the URC for reconsideration.

(d) The UR physician's decision to transfer in spite of an inconsistent answer to DMS-1 Questions 3D, E, F, 9A, B, C, 10 or 11, constitutes an adequate basis to support the transfer.

VII. *Transfer Trauma and Possible Harm To Patients*

77. *Plaintiffs assert* that:

(a) Under the present system of long term care facilities and reimbursement in New York, defendants' UR/DMS-1 system has a very significant adverse impact on Medicaid patients in SNF's and HRF's.

(b) UR determinations recommending a lower level-of-care, which are not voluntarily accepted by the patient, are likely to be followed by either:

(1) a subsequent physical or psychological occurrence requiring reversal by the UR of its adverse finding;

(2) hospitalization;

(3) death.

(c) "Transfer trauma" is a name ascribed to the recognized phenomenon that the transfer of geriatric patients to an unfamiliar surrounding is associated with increased rates or mortality and morbidity.

(d) The anticipation of relocation is also associated with effects as severe as those caused by relocation itself.

(e) It is not presently possible to predict, with any degree of certainty, the likelihood or degree of transfer trauma associated with a relocation.

(f) The general characteristics of nursing home patients —e.g. elderly, infirm, frail, confused—are also those associated with a high risk of transfer trauma and transfer of such patients involves a generally high level of risk.

(g) The intense kind of pre-transfer preparations and post transfer follow-up necessary to significantly reduce the risks of transfer trauma, is not presently available and would require, *inter alia,* holding beds vacant in receiving facilities for a period of time as well as trained personnel to make it work.

(h) Such preparation and follow-up should be *required* in any case where transfer is unavoidable but it still would not reduce the risk to the point where transfer could become a preferred alternative.

78. *Defendants assert* that:

(a) Transfer trauma is a name ascribed to the alleged phenomenon that the transfer of geriatric patients to unfamiliar surroundings causes some psychological trauma. Expressly excluded is the concept that transfer trauma is significant enough to have physiological implications for the person transferred. Nor does transfer trauma cause increased rates of mortality or morbidity for those transferred.

(b) To the extent transfer trauma exists:

1. It is virtually unrelated to the anticipation of transfer.
2. Transfer patients quickly recover in their new surroundings from any adverse reaction.
3. The better the patient's health the less effect the transfer has on him.
4. It is reduced and can be eliminated by preparing the patient for the transfer.
5. It can be determined on a case by case basis whether trauma will occur.

79. The likelihood and degree of trauma associated with relocation (transfer trauma) is in part a function of the extent to which the relocation was voluntary and the degree of environmental change entailed by the relocation.

VIII. *Adequacy of DMS-1 and Quality of DMS-1 Assessments*

80. *Plaintiffs assert* that:

(a) As implemented, the DMS-1/UR system does not provide uniform, consistent or adequate assessments of patient needs.

(b) The DMS-1 and scoring system is inadequate.

(e) The results of its implementation are inconsistent and inadequate.

(d) The DMS-1 numerical system can easily be manipulated to achieve a desired outcome.

(f) Utilization review and non-UR transfers are used by facilities to rid themselves of patients they do not wish to retain.

(g) DMS-1 numerical scores do not correlate with the nursing-hour needs of patients the DMS-1 purports to describe, although nursing-hour needs are the principal determinant of a patient's level-of-care needs.

(h) It is difficult to prepare an adequate assessment if the medical records are not accurate and complete, although there is great variability in the quality of medical record keeping between facilities and the overall quality at many facilities is inadequate.

(i) The DMS-1 does not reflect psychological dependency, other psycho-social factors, psychiatric or behavioral problems, although a psycho-social assessment is a necessary part of patient assessment.

(j) Adequate consideration of psycho-social needs in the UR process requires that a psycho-social assessment be built into whatever assessment instrument is used.

81. *Defendants assert* that:

(a) The DMS-1 provides an adequate basis for a doctor to determine what level of care a specific individual requires.

(b) The DMS-1 is being filled out properly at the facilities. This is true both where the patient is eventually reviewed by the URC and where such review is unnecessary. The defendants have conducted various periodic checks to substantiate this.

(c) The DMS-1 scoring sheet is a useful and accurate tool to determine which cases require further review by the URC to see if the patient can be transferred.

(d) Since the development of the DMS-1 and the development of the scoring sheet, nursing home beds have been better utilized. The DMS-1, the scoring sheet and the UR process are all *partly* responsible for this improvement.

(e) The URC serves as an effective check to make sure that existing nursing home beds are used by those patients who need them.

(f) Level-of-care needs of patients are determined by the patients' conditions and, primarily, by the nursing needs of their condition.

82. The implementation of the DMS-1 form and numerical criteria in 1977 was met with opposition from health care providers and from professional and other sources.

83. *Plaintiffs assert* that:

(a) The present DMS-1 scoring system has been strongly criticized since its inception by health care providers, professionals and consumer advocates.

(b) A principal objection to the present DMS-1 system, at the time of its implementation and thereafter, was its failure to incorporate psycho-social factors into the form.

(c) The Department of Health has been aware of the shortcomings in the DMS-1, the numerical standards, and the way it is implemented since its promulgation but has failed to correct these shortcomings.

IX. *Defendant's Monitoring of Costs and Benefits of System*

84. Defendants are obligated (pursuant to 42 USC §§ 1396e(a), 1396(g), 1396x(j)(12) and (k), and 42 CFR

456.206) to maintain an effective program of monitoring and control of the UR process.

85. *Plaintiffs assert* that defendants have not effectively monitored or controlled the functioning of the UR process.

86. Defendants are required pursuant to 42 USC 1396a (a)(19) and 45 CFR 206.10(a)(11) to provide such safeguards as may be necessary in the operation of the long term care system in New York, to assure that eligibility for care and services will be determined, and that care and services will be provided in a manner consistent with simplicity of administration and the best interests of the recipients.

87. *Plaintiffs assert* that:

(a) Defendants' system of long term care in general, and the utilization review system in particular, do not operate in a manner which is consistent with either simplicity of administration or the best interests of patients.

(b) Defendants have failed to provide the safeguards necessary to assure that eligibility is determined and care provided in a manner consistent with simplicity of administration and the best interest of patients.

88. *Defendants assert* that:

(a) The UR system is required by federal law. UR also guarantees proper utilization of scarce medical resources.

(b) As there is a present shortage of SNF and HRF beds, the transfer of a patient to a lower level of care ordinarily results in another patient filling the vacated bed. Accordingly, there are no short term financial savings in nursing home costs.

(c) The UR process reduces inappropriate placements and continued stays in nursing homes. Accordingly, it may reduce the number of nursing home beds that would other-

wise have been thought necessary in the future. This may result in some long term savings.

(d) To the extent the UR process results in patients being moved from hospitals to newly available nursing home beds, there are some cost savings.

(e) Defendants allege the present UR system has a positive utility which justifies its costs.

(f) It is medically undesirable for a patient to receive more care than he needs. For example, a patient requiring only HRF care will be better off in an HRF than in a SNF or in a hospital.

89. *Plaintiffs' assert* that whatever the theoretical benefits to defendants of the UR system, these benefits are not realized because the fact that:

> (a) the UR system itself entails a very substantial administrative cost (exclusive of the human cost extracted from the patients) and
>
> (b) the UR system does not result [in] a sufficient overall number of transfers or free a sufficient number of beds to fulfill defendants' objectives or to justify the cost.

90. *Plaintiffs assert* that in actual practice defendants UR system

> (a) has not worked to reduce Medicaid expenditures through the differential in reimbursement rates between higher and lower levels of care;
>
> (b) has not produced cost savings or other economic benefit;
>
> (c) has not fulfilled any economic or other legitimate governmental objective.

91. *Plaintiffs assert* that the time spent by nursing home professional staff in completing DMS-1 forms and in doing other related UR tasks has a significant impact in reducing the amount of such time spent on caring for patients.

92. *Defendants assert* that the staff needs, if any, which are created by the time spent on the UR process are met by the facilities adding additional staff.

93. Defendants have not conducted any specific study of DMS-1's in adverse UR determinations to determine whether they were properly filled out and properly matched to the patient.

94. Defendants do not know:

(a) how many patients receive adverse UR determinations;

(b) the number of [sic] percentage of such patients who disagree with the determinations;

(c) the percentage of such cases which are appealed by request for hearing;

(d) the number or percentage of patients who are transferred as a result of adverse UR determinations;

(e) what happens to patients who are transferred;

(f) what happens to patients who are not transferred;

(g) the economic costs of the present UR/DMS-1 system on patients;

(h) what is the impact of the present UR/DMS-1 system on patients.

94a. Defendants have not conducted any study or inquiry to determine the answers to (a)-(h) above.

95. Defendants rely on their fair hearing process to indicate whether its policies regarding utilization review are being followed.

96. *Defendants assert* that they also rely on Professional Medical Review (PMR) and Independent Professional Review (IPR) for this purpose.

X. *Possible Modifications of the DMS-1*

97. The Department of Health established a task force shortly after the DMS-1 numerical system was introduced, for the purpose of revising the DMS-1 and developing an alternative form, which would include a psycho-social assessment.

98. The chairman of that task force was David Glaser, administrator of the Margaret Tietz Center for Nursing Care and president of the New York Association of Homes for the Aging.

99. The task force included staff from the Department of Health, health care providers, health care professional, consumer representatives and others.

100. The task force developed a series of forms known as "PPAS" (Patient Placement and Assessment System) [Plaintiffs' Exhibit 11].

101. The PPAS incorporated DMS-1 form elements and added to them.

102. A field test of the PPAS was conducted by the Department of Health in the spring of 1978.

103. The field test was aborted because the particular forms proved unworkable.

104. The results of the field test were compiled by the Department of Health and issued by the Department in October, 1978. [Plaintiffs Exhibit 19].

105. *Plaintiffs assert* that:

(a) The "PPAS Task Force" was established in response to the outcry of criticism that accompanied the DMS-1 numerical system.

(b) The PPAS Task Force and the results of the field test reaffirmed: (1) the deficiencies in the present DMS-1 system and (2) the need to incorporate a psycho-social assessment into the form.

XI. *Possible Modifications of the Present Nursing Home Classification And Reimbursement System*

106. *Plaintiffs assert* that:

(a) Preferable alternatives to the present system of UR and long term care include:

(1) reclassification of beds within existing single level facilities to enable the large majority of level-of-care changes to be made without requiring relocation out of the facility;

(2) having a single all-inclusive level-of-care, and a single average reimbursement rate, covering both SNF and HRF;

(3) having beds whose classification shifts depending on the patient occupying it, thus enabling many level-of-care changes to be accomplished without transfer at all.

(b) To the extent accomplishment of the above requires waivers of federal requirements, the Department of HEW has granted such waivers.

107. Facilities which have level-of-care classifications enabling them to provide for several levels of care within the same facility are preferable to single level facilities.

108. Multi-level facilities make it easier to meet the long term care needs of smaller communities.

109. Transfer trauma (to the extent it exists) is less likely to occur and will be less significant when the transfer can

take place within a facility than if it requires relocation to another facility.

110. *Plaintiffs assert* that

(a) A UR recommendation of transfer which can be accomplished within a facility, is more likely to be voluntarily accepted by the patient and more likely to be actually carried out than one which would require out-of-facility relocation.

(b) From a fiscal and economic point of view, multiple levels-of-care are substantially more efficient and a better use of resources than single level facilities.

(c) From a medical perspective, nursing homes which offer a single level-of-care are:

(1) medically inferior to facilities which can provide for several levels of need within the same facility (i.e., multi-level) and

(2) are medically unacceptable.

111. SNF's and HRF's have different physical requirements. Most single level SNF's could meet or be easily adapted to meet HRF physical requirements (approximately 291 facilities).

112. *Plaintiffs assert* that most single level HRF's could also meet or be easily adapted to meet SNF physical requirements (approximately 30 facilities).

113. *Defendants assert* that the different physical requirements could render it virtually impossible for an HRF to meet SNF requirements. For example, SNFs must have bathrooms in each room. HRFs do not have such a requirement.

114. Medicaid reimbursement rates are cost-related. While the HRF reimbursement rate is ordinarily lower than the SNF reimbursement rate, HRF costs are also

ordinarily correspondingly lower than SNF costs. Thus SNF beds should not be more profitable to the operator of a nursing home.

115. *Plaintiffs assert* that

(a) Reimbursement mechanisms are available which would allow conversion of single level facilities to multi-level facilities.

(b) At present, the New York State Medicaid reimbursement formula builds in disincentives which discourage single level SNF's from seeking re-classification to multi-level facilities.

116. *Defendants assert* that there are no disincentives for single level facilities to convert to multi-level facilities.

117. At the time the present DMS-1 numerical system was implemented, defendants' "Task Force on Patient Assessment and Placement" (Task Force IV) (Plaintiffs' Exhibit 12), envisioned the re-classification of beds within the facilities to other levels of care with a result that single level facilities would be modified to multi-level.

118. At the time the present DMS-1 numerical system was implemented, it was the publicly stated position of the Deputy Commissioner of Health responsible for utilization review and development of that system, that:

a) By and large the policy has been that it's difficult, often inhuman and very often dangerous to take established patients from a long term care facility and require that they move to another facility.

b) Our intent is not to move anybody. Our intent is that there are patients who do not meet definitions of SNF. The way to handle that is to change the bed not the patient.

c) All facilities should be multi-level and should include the SNF, HRF and DCF categories. (Plaintiffs' Exhibit 13)

119. The reclassification of levels-of-care within facilities thus envisioned has, by and large, not been done.

120. The phased-in reclassification of most current single-level facilities to multi-level facilities is administratively feasible.

121. *Plaintiffs assert* that the Commissioner of Health can re-classify the level of nursing home beds to other levels of care.

122. *Defendants assert* that whether the Commissioner of Health has the legislative authority to re-classify the level of nursing home beds is an undetermined question of state law.

XII. *Plaintiffs' Summaries of DMS-1 Forms Analyzed*

124. Plaintiffs receive approximately 497 "notices of adverse UR determinations" with attached DMS-1's and statement of reasons, plus 29 adverse UR determinations from Westchester Co. facilities. These represent virtually every adverse UR determination from the time the *Yaretsky* preliminary injunction was implemented, on or about 2/1/78 up to 5/15/78.

125. Defendants provided the plaintiffs with approximately 500 DMS-1 forms for the month of September, 1978, which were randomly selected by the defendants.

126. Therefore, plaintiffs' DMS-1 analysis reviewed more than 1,500 forms (497+26+552+500).

127. The data in the sample of DMS-1 forms from September, 1978 is not significantly different from the data in the sample from January-March, 1978.

128. Plaintiffs' Exhibit 31 is a series of 19 tables which summarize data collected from those DMS-1 forms; the tables constituting plaintiffs' Exhibit 31 are accurate representations of what they purport to summarize and may be admitted into evidence.

129. *Plaintiffs assert* that the summaries are accurate representations of all DMS-1 forms, not just those summarized.

130. *Defendants do* not admit plaintiffs' assertion.

131. The following statements are true characterizations of the tables in plaintiffs Exhibit 31:

Table

1 The percentage of SNF and HRF patients is the same for adverse and non-adverse samples for all periods and is approximately equal to the overall statewide percentage: 70% SNF, 30% HRF.

2 Of the adverse UR decisions:

62.9% recommend SNF to HRF transfer;
23.9% recommend HRF to SNF transfer;
5.6 recommend SNF to "other-lower" transfer;
and 7.6% recommend HRF to "other-lower" transfer.

3 (a) Of the adverse UR DMS-1's, 28.6% are missing the UR "screener" signature.

(b) This is similar to the percentage missing the screener signature in both the Jan.-March (24.3%) and September (21.3%) non-adverse groups.

(c) 12.3% of the adverse DMS-1's are missing signatures of either the RN who completed

the form or the UR doctor; 9.2% are missing the UR doctor's signature, 11.1% are missing either the doctor's signature or his placement recommendation.

(d) In 3.5% of the adverse cases, the transfer decision reflected in the notice is different than that recommended by the UR doctor.

(e) A majority of non-adverse UR decisions for both the January-March (55.1%) and September (56.6%) periods were referred to and processed by the UR doctor.

4 (a) Of the adverse cases, 35% of the patients were identified on the DMS-1 as having been admitted prior to 3/1/77; of those 89.7% of the forms contained a numerical score.

(b) Of the non-adverse cases, 56.6% of the Jan.-March sample and 34.5% of the September samples were identified as having been admitted prior to 3/1/77; of those 61% and 56.1%, respectively, contained a numerical score.

5-6 (a) 19% of the notices of adverse UR sent out statewide did not list the address or phone of legal services; in New York City this percentage was 3%; upstate the percentage was 33.2%.

(b) 8% of the notices had no statement of reasons attached; of those that did, 27.3% did not state specific reasons for the adverse decision.

7 9 adverse DMS-1's indicated that the attending physician disagreed with the decision; in none of

those cases did the DMS-1 contain the signature of a second UR physician.

8 Attending physicans who are on staff (list same address as nursing home) are less likely to dissent from the UR determination (1 of 9 dissents) or 11.1%) in proportion to their numbers (28.7% of all adverse cases) than are attending physicians from outside the facility (representing 88.9% of dissents and 70.6% of all adverse cases).

9 (a) Of the patients recommended for transfer to HRF, the DMS-1 indicates that 17.8% require some item of nursing care and therapy listed in question 3A, and 15% suffer from incontinence.

(b) Of the patients recommended for transfer to adult home or other lower level, the DMS-1 indicates that 13.8% require some item of nursing care and therapy listed in question 3A, and 9.8% suffer from incontinence.

10 (a) Of the patients recommended for transfer to HRF, the DMS-1 indicates that 75.9% are likely to suffer complications and/or show instability requiring skilled nursing care or supervision; 61.7% indicate both.

(b) Of the patients recommended for transfer to adult home or other lower level, the DMS-1 indicates that 46% are likely to suffer complications and/or show instability requiring skilled nursing care or supervision; 36.4% indicate both.

(c) Of the patients recommended for transfer to SNF, the DMS-1 indicates that 16.4% are *neither* likely to suffer complications *or* show

instability requiring skilled nursing care or supervision.

11 (a) Of the patients recommended for transfer to HRF, the DMS-1 indicates that 72.3% require 7 days per week of skilled nursing care.

(b) Of the patients recommended for transfer to adult home or other lower level, the DMS-1 indicates that 54.9% require one or more days per week of skilled nursing care and 43.1% require seven days per week.

(c) Of the patients recommended for transfer to SNF, the DMS-1 indicates that 17.5% require no days of skilled nursing care, 30% require 4 or fewer days per week and 68% require 7 days per week.

12 (a) Of the patients recommended for transfer to adult home or other lower level, the DMS-1 indicates that 70.8% require some help in one or more functions areas and 10.8% require total help (or "cannot") in one or more areas.

(b) Of patients recommended for transfer to HRF, the DMS-1 indicates that 13.1% require total help (or "cannot") in one or more areas.

13 (a) Of the patients recommended for transfer to adult home or other lower level, the DMS-1 indicates that 63.6% are "sometimes" impaired in one or more mental status categories and 6.1% are always impaired (or never alert).

(b) Of the patients recommended for transfer to HRF, the DMS-1 indicates that 8.9% are always impaired (or never alert) in one or more mental status categories.

14 (a) In 32.5% of the adverse UR cases recommending transfer, the RN who filled out the DMS-1 indicated that the patient should not be considered for another level of care.

(b) In an additional 6.6% of the cases, the RN who filled out the form did not answer the question.

15 (a) Of the patients recommended for transfer to adult home or other lower level, the DMS-1 indicates that 37.5% are considered medically qualified for SNF care under Medicare standards; 49.7% are listed as questionable; 20.8% are listed as not covered.

(b) Of the patients recommended for transfer to HRF, the DMS-1 indicates that 59.8% are considered medically qualified for SNF care under Medicare standards; 27.4% are listed as questionable; an 12.7% are listed as not covered.

(c) Of the patients recommended for transfer to SNF, the DMS-1 indicates that 29% are *not* considered medically qualified for SNF care; 4.3% are listed as questionable.

16 7% of the adverse cases were free from facial defect or inconsistency.

17 Men patients are somewhat more likely to be recommended for transfer than are women (30.7% in adverse group vs. 25.4% in Jan-March and 26.9% in September non adverse groups).

18 Of the patients recommended for transfer, the mean age is 77.9 years, the mode is 81-85, 80.8% are more than 70 years old, and 93% are more than 60 years old.

19 162 nursing homes account for 100% of the adverse UR recommendations for the period of approximately 2/1/78 to 5/15/78; 22 homes account for 43% of the cases; 9 homes account for 24% of the cases.

Plaintiffs' Summaries for Fair Hearings Files Analyzed

132. Plaintiffs received from the defendants approximately 150 fair hearing decisions with supporting documents. Of these, 48 are fair hearings rendered in November and December, 1977 (period one); 53 are decisions rendered in May and June of 1978 (period two); and 46 are decisions rendered in September, 1978 (period three).

133. The 147 fair hearing decisions received by plaintiffs represent all fair hearing decisions rendered by the Department of Social Services for the months of November and December, 1977, and May, June and September of 1978.

134. Plaintiffs' Exhibit 30 is a series of 17 charts which summarize data collected from these fair hearing files. Charts No. 1, 6, 7 and 17 are based on a review of all 147 files. The remaining charts are based on a review of 106 files: a random sample of 30 and each from periods one and two, plus all 46 files from period three.

135. The charts constituting plaintiffs' Exhibit 30 are accurate representations of what they purport to summarize and may be admitted into evidence.

136. *Plaintiffs assert* that the summaries are accurate representations of all UR fair hearing files.

137. *Defendants* do not admit plaintiffs' assertion.

138. The following statements are true characterizations of the charts constituting plaintiffs' Exhibit 30:

Pretrial Order

(Statements Derived From Chart Nos. 1, 6, 7, and 17)

(a) 4 nursing homes account for 20% of all fair hearings; 11 homes account for 40 % (58/147) of all hearings; and 31 homes account for 70% (102/147) of all hearings.

(b) 75% (110/147) of all fair hearings were requested by patients in single level facilities.

(c) Single level SNF's account for 94% of all hearings requested by SNF patients. (86/91)

(d) 62% of all the hearings held involved transfers out of an SNF facility. (91/147)

(e) 12% of the hearings involved upward transfers from an HRF to an SNF. (17/147)

(f) In 60% of the hearings involving the issue of an upward transfer from HRF to SNF, the patient/recipient prevailed at the fair hearing.

(Statement Derived From the Remaining Charts)

(a) 16% of the hearings were pro se.

(b) Unrepresented clients lost 60% of their hearings, compared with a 43% average loss by represented patients.

(c) of 106 decisions, the recommendation of the hearing officer (hereinafter H.O.) was adopted by Albany in 56 cases, reversed in 15 cases, in nine there was "no issue"; and in 26 cases the hearing officer did not make a recommendation.

(d) Albany reversed the H.O's recommendation in 12 out of 39 cases (or 31%) where the H.O. made a recommendation in favor of the appellant; Albany reversed the H.O.'s recommendation in 3 out of 32 cases (or 9% where the H.O. made an adverse recommendation. In the more recent cases of September 1978 (period 3), Albany reversed the H.O.'s recommendation in 9 out of 19 cases

(or 47%) where the H.O. made a recommendation in favor of the appellant.

(e) Where Albany decides differently than the hearing officer, Albany's decision is for transferring the patient in 80% of the cases; for September, 1978 the percentage is 90%.

(f) In 24% of the hearings, the DMS-1's relied upon did not have the signature of the utilization review committee representative, and in 60% of these cases the fair hearing decision upheld the transfer.

(g) In 8% of the hearings, the DMS-1 relied upon was not signed by the utilization review committee physician. In 3% of these cases the fair hearing decision upheld the transfer.

(h) In 30% of the cases, the patient was admitted to the facility prior to March, 1977, yet the DMS-1 relied upon as scored. In 81% of these cases the fair hearing decision upheld the transfer.

(i) In 38% of the cases, on the DMS-1 Form question #D (Is the patient's condition unstable so then an RN must detect/evaluate need for modifications treatment/care on a daily basis?) was either left blank or answered "yes." In 38% of these cases the fair hearing decision upheld the transfer.

(j) In 42% of the cases, question 3E on the DMS-1 (Is there a high probability that complications would arise in caring for the patient without skilled nursing supervision of the treatment program on a daily basis?) was either not filled out or was answered "yes." In 49% of these cases the fair hearing decision upheld the transfer.

(k) In 41% of the cases, question 3F on the DMS-1 (Circle the *minimum* number of days/weeks of complex

nursing supervision) was either not filled out or was filled out indicating seven days per week required. In 49% of these cases the fair hearing decision upheld the transfer.

(l) In 35% of the cases, question 9A (Should the patient be considered for another level of care?) was not filled out or was answered "no." In 54% (20/37) of these cases the fair hearing decision upheld the transfer.

(m) For hearing decisions rendered in periods 2 and 3, 49% of the "statements of exact reasons" were not signed by the utilization review physician. In 58% of these cases the fair hearing decision upheld the transfer.

(n) For hearing decisions rendered in periods 2 and 3, 32% had "statements of exact reason" that did not specify change or improved conditions of the patient. In 58% of these cases the fair hearing decision upheld the transfer.

(o) For the "facial" errors set forth in sub-paragraphs f through n, there appear to be no overall pattern of improvement from period 1 through period 3.

(p) The rate of "facial errors on DMS-1's for which fair hearings were requested is approximately equal to the facial error rate of all adverse DMS-1's. (Fair hearing and DMS-1 summary).

(q) For period 1, in 9 of the decisions which were affirmed, the decision was based on documents submitted by the agency without the agency representative present, although the only other evidence was appellant witnesses opposing transfer.

(r) For period 3, this was true in 4 cases which were affirmed.

(s) For period 3, of the 20 hearing decisions not affirmed, at least 8 were not affirmed for technical defects in procedures; at least 6 were based on a change in the patient's

physical status or a report by a physician made after the initial DMS-1.

(t) For period 2, at least 8 of the 15 decisions not affirmed were on grounds of procedural irregularities.

XIV. *Status of Admissions Made At Depositions*

139. The statements in the depositions of the following persons are the statements of defendants (except as otherwise stated in the depositions) and such statements may be admitted into evidence:

Elizabeth Dinehart
Roger Herdman
Anthony Maddaloni
Phillip Nostramo
Richard Ruid
Henry Stevenson

* * *

March 5, 1979
N.Y., N.Y.

So ordered
/s/ Constance Baker Motley
United States District Judge

Notice of Motion for Summary Judgment

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

[Title omitted in printing.]

SIRS:

PLEASE TAKE NOTICE, that upon the annexed Local Rule 9(g) statement of material facts as to which plaintiffs contend there is no genuine issue to be tried, the letter of Sherry J. Leiwant, Assistant Regional Attorney for HEW, dated August 10, 1979, plaintiffs' memorandum in support of the instant motion, the depositions and plaintiffs' exhibits in this case, and upon all prior proceedings had and papers filed herein, including the stipulation of consent to entry of partial final judgment, dated May 29, 1979, the Joint Pre-Trial Order, signed March 5, 1979, and the plaintiffs' pre-trial memorandum, dated February 22, 1979, the undersigned will move this Court, before the Honorable Constance Baker Motley, in Courtroom 619 of the United States Courthouse, Foley Square, New York, New York, on September 21, 1979, at 10:00 a.m., or as soon thereafter as counsel can be heard,

1. for an order EITHER

(A)(1) directing that the stipulation of consent to entry of partial final judgment be entered as a partial final judgment, pursuant to paragraph XIII of said stipulation, on the ground that defendants' compliance with the judgment or any portion thereof will not cause federal financial participation in the New York State Medicaid Program to be terminated or reduced; and

(A)(2) pursuant to Rule 56 of the Federal Rules of Civil Procedure and 28 U.S.C. § 2201, granting summary

judgment in favor of the plaintiffs and the plaintiff class, on the ground that there is no genuine issue as to any fact material to this case and that plaintiffs and plaintiff class members are entitled to a judgment as a matter of law, declaring (a) that they each have a constitutional right under the Due Process Clause of the Fourteenth Amendment to adequate notice and the opportunity for an evidentiary hearing prior to a transfer initiated by a nursing facility without utilization review and prior to transfer to a higher level of nursing care, and (b) that the Due Process Clause of the Fourteenth Amendment and the laws of the State of New York prohibit the State Commissioner of Social Services and his agent from rejecting and reversing a hearing officer recommendation after fair hearing favorable to a plaintiff or plaintiff class member without first preparing, reviewing, and adequately considering together with all exhibits, a verbatim transcript of the hearing; and

(A)(3) pursuant to Rule 65 of the Federal Rules of Civil Procedure and 28 U.S.C. § 2202, granting a permanent injunction enjoining the defendants, and their officers, agents, servants, employees, attorneys, and successors in office, and all persons in active concert or participation with them who receive actual notice of this judgment by personal service or otherwise, (a) to enforce and comply with each and every provision of the partial final judgment, *supra,* (b) to provide every affected plaintiff and plaintiff class member with adequate notice and the opportunity for an evidentiary hearing prior to a transfer to a higher level of nursing care and prior to a transfer initiated by a nursing facility without utilization review, and (c) to prepare, review, and adequately consider, together with all exhibits, a verbatim transcript of the fair hearing prior to rejecting and reversing a hearing officer recommendation favorable to a plaintiff or plaintiff class member;

OR, IN THE ALTERNATIVE,

Notice of Motion

(B)(1) pursuant to Rule 56 of the Federal Rules of Civil Procedure and 28 U.S.C. § 2201, granting summary judgment in favor of the plaintiffs and the plaintiff class, on the grounds that there is no genuine issue as to any fact material to this case and that the plaintiffs and plaintiff class members are entitled to a judgment as a matter of law, declaring that, under the United States Constitution, the Social Security Act and implementing federal regulations, and the laws of the State of New York, they each have all the rights set forth at pages 5-11 of the Joint Pre-Trial Order, signed March 5, 1979, in this case; and

(B)(2) pursuant to Rule 65 of the Federal Rules of Civil Procedure and 28 U.S.C. § 2202, granting a permanent injunction enjoining the defendants, and their officers, agents, servants, employees, attorneys, and successors in office, and all persons in active concert or participation with them who receive actual notice of this judgment by personal service or otherwise, to enforce and comply with each and every provision set forth at pages 5-11 of the approved Joint Pre-Trial Order in this case; AND

2. for an order reserving for later determination by this Court, upon appropriate motion to be made at a time set by the Court, the issue of plaintiffs' entitlement to an award of reasonable attorneys' fees, expenses, costs, and disbursements in this case; AND

3. for an order granting such other and further relief as to this Court may seem just and proper.

Defendants are requested to serve their answering papers, if any, to this motion upon plaintiffs' counsel no later than 5:00 p.m., September 17, 1979.

Dated: New York, New York
September 11, 1979

Yours, etc.,

[Attorneys' subscriptions and addresses omitted in printing.]
Attorneys for Plaintiffs

Plaintiffs' Rule 9(g) Statement

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

[Title omitted in printing.]

Plaintiffs hereby incorporate into and as constituting this statement of material facts as to which there is no genuine issue to be tried the statements contained at pages 25-68 of the Joint Pre-Trial Order, signed March 5, 1979, except for the following numbered statements: Nos. 9, 14, 26, 28, 35, 46, 49, 49a, 55, 59, 64, 69, 76, 78, 81, 88, 92, 96, 113, 116, 122, 130, 137.

Dated: New York, New York
September 11, 1979

Respectfully submitted,

[Attorneys' subscription and addresses omitted in printing.]
Attorneys for Plaintiffs

Affidavit of Philip M. Gassel

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

[Title omitted in printing.]

STATE OF NEW YORK
COUNTY OF NEW YORK } ss.:

PHILIP M. GASSEL, being duly sworn, deposes and says:

1. I am one of the attorneys for the plaintiffs and make this affidavit in further support of plaintiffs' motion that the Court enter the parties' "Stipulation of Consent to Entry of Partial Final Judgment" as the judgment of the Court.

2. The grounds for said motion were that the precondition for entry of a judgment, set forth in the stipulation, has been satisfied. That precondition was the receipt of reasonable assurances from the Department of H.E.W. that the State will not lose federal Medicaid reimbursement (i.e. "federal financial participation," or "FFP") as a result of the judgment. The necessary assurances, plaintiffs contended, were contained in a letter, dated August 10, 1979, from HEW counsel to defendants' attorney (see plaintiff's memorandum in support of the motion, at pp. 4-6, and letter annexed thereto).

3. Following receipt of the August 10 letter, defendants' counsel expressed dissatisfaction with the assurances contained therein. Conversations ensued between counsel for plaintiffs, defendants and HEW, on September 4, 5 and 6, 1979 regarding modifications of the letter which would satisfy the state. After conferring with his clients, defendants' counsel negotiated with counsel for HEW regarding the addition of certain clarifying language to the letter. A

verbal agreement was reached in which counsel for defendants expressly represented to me, based on his conversations with his clients and with HEW, that receipt of a letter from HEW with the requested clarification, would be satisfactory and permit entry of the judgment. I was told by counsel for HEW that defendants' counsel made a similar representation to her.

4. Subsequent to the filing of this motion for entry of judgment based on the settlement stipulation, HEW Regional Administrator William Toby sent a letter to defendants' attorneys, dated September 13, 1979. (Copy attached hereto). Per the verbal agreement, the letter contains all of the elements of the earlier August 10 letter plus the agreed upon statements of clarification.

5. I have since been advised by defendants' counsel that his clients are still not satisfied. I am further advised that their dissatisfaction concerns a sentence in Mr. Toby's letter referring to possible loss of reimbursement for individual patients "in the event that an HEW audit found that an individual patient had stayed in a skilled nursing facility despite a utilization control determination that he did not need skilled nursing care." Although this sentence is taken verbatim from the earlier August 10 letter, no objection to it has heretofore been expressed by defendants. Indeed, at a meeting at the HEW offices regarding the settlement, on July 10, 1979, which I attended, George M. Warner, M.D., Assistant to the Deputy Director, Division of Health Facilities Standards and Control of the N. Y. State Health Department Office of Health Systems Management, stated the willingness of the Department of Health to, if necessary, absorb possible individual Medicaid "disallowances" of this type.*

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* Plaintiffs' memorandum in support of this motion (p. 6) explains why, in any event, no such disallowance can occur under the terms of the settlement stipulation.

6. In light of defendants' verbal agreements and representations described above, the September 13 letter from HEW is sufficient, without more, to permit entry of judgment on the stipulated settlement previously signed by the parties.

s/ PHILIP M. GASSEL

Sworn to before me this
20th day of September, 1979.
[Jurat omitted in printing.]

Affidavit of Kenneth A. Thomas in Support of Motion to Join HEW as a Defendant and in Opposition to Motion for Summary Judgment

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

[Title omitted in printing.]

STATE OF NEW YORK }
COUNTY OF NEW YORK } ss.:

KENNETH A. THOMAS, being duly sworn, deposes and says:

1. I am an Assistant Attorney General in the office of ROBERT ABRAMS, Attorney General of the State of New York, attorney for defendants and I make this affidavit in opposition to plaintiffs' motion for an order directing that the stipulation of consent to entry of partial final judgment be entered as a partial final judgment pursuant to paragraph XIII of said stipulation on the ground that defendants' compliance with the judgment or any portion thereof will not cause federal financial participation in the New York Medicaid Program to be terminated or reduced and in support of defendants' motion to join the United States Department of Health, Education and Welfare as a party to this action pursuant to Rules 19 and 21 of the Federal Rules of Civil Procedure.

2. On May 29, 1979, plaintiffs and defendants, by their respective attorneys, executed a stipulation of consent to entry of partial final judgment ("the stipulation") which, if entered as a judgment, would settle many of the issues raised in this lawsuit including all those issues which would have required a trial. Among the issues covered by

the stipulation were the alleged inadequacies in utilization review procedures, as well as, the effect of transfer trauma on nursing home patients.

The stipulation, a copy of which was forwarded to the Court on May 29, 1979, requires, among other things, that the utilization review committee receive and consider a written and signed psycho-social evaluation indicating the patient's response to possible transfer, that a written discharge plan be prepared for the patient to be transferred and that no transfer may be approved where there exists certain defects in the underlying paperwork. (See Stipulation ¶ II, A-D.) The stipulation, also spells out certain procedural rights of patients faced with transfer including the right to timely and adequate notice of an adverse utilization review finding and the right to have unencumbered access to review and copy the contents of their file. (See Stipulation ¶ III.) The issue of transfer trauma was resolved in the stipulation by providing that a proposed transfer of a patient is medically contra-indicated unless the patient voluntarily consents to the transfer. (See Stipulation ¶ II, F.)

3. It is the position of the State defendants that the stipulation is in the best interests of both the State and nursing home patients since it affords greater protection to patients facing transfer while improving the utilization review procedures. (See affidavit of Robert F. Skerrett, Acting Deputy Commissioner of the New York State Department of Social Services, sworn to September 19, 1979, ¶ 3, hereinafter "the Skerrett affidavit").

4. As set forth in the Skerrett affidavit, the federal government provides approximately 50% of the funds for the Medicaid program in New York State. (See Skerrett affidavit, ¶ 6.) Federal funding of this program, which includes funds for patients in nursing homes, can be taken

away where the United States Department of Health, Education and Welfare ("HEW"), determines that the State is not administering the program in accord with federal regulations.

Since the stipulation requires changes in the State's administration of utilization review, the State defendants were concerned that implementation of the stipulation could jeopardize federal financial participation in the Medicaid program in New York State. Consequently, at defendants' request paragraph XIII of the stipulation provides, in part:

> "Defendants are not bound by and judicial approval of this judgment shall not be sought by the parties until the U.S. Department of Health, Education and Welfare (hereinafter "HEW") represents, or it is judicially determined, that defendants' compliance with this judgment or any portion thereof will not cause federal financial participation (hereinafter "FFP") in the New York State Medicaid Program to be terminated or reduced . . ."

5. In a letter dated May 29, 1979, plaintiffs and defendants forwarded to William Toby, Regional Administrator, Health Care Financing Administration, HEW, a copy of the stipulation and formally requested HEW to review the stipulation and advise them "whether FFP in the State's Medicaid program, under Title XIX of the Social Security Act, will be terminated or reduced if defendants comply with a federal court order incorporating the terms of the stipulation." A copy of the letter is annexed hereto as Exhibit A.

6. Subsequent to the May 29, 1979 letter to HEW, plaintiffs and defendants met with representatives of HEW and entered into further discussions which culminated in a September 13, 1979 letter from Mr. Toby to Attorney Gen-

eral Robert Abrams advising the State what possible effect implementation of the stipulation might have on receipt of FFP by the State for the Medicaid program. While HEW did not express any views as to the likelihood that implementation of the terms of the stipulation would be contrary to federal utilization review requirements, HEW did represent that any loss of FFP as a result of a finding that the State was out of compliance with federal utilization review requirements, Title XIX, or the New York State Plan would be prospective only. However, HEW stated that the State could lose FFP as a result of implementation of the stipulation in the event that a HEW audit found that an individual patient had stayed in a skilled nursing facility despite a utilization review determination that he did not need skilled nursing care. In that event, federal payments for that individual patient could be disallowed.

7. It is impossible to estimate the number of patients who might be effected by a HEW audit as described in the Sept. 13, 1979 letter. The number of such patients may be indicated by the number of fair hearings requested by patients who object to adverse utilization review determinations since such patients would be likely to exercise their right to withhold consent as to a proposed transfer. On the other hand, the number of such patients may be much higher since there may be many patients now being transferred who would refuse to give their consent to a transfer if that option were available but who do not pursue their right to an administrative appeal. (See Skerrett affidavit, ¶ 7.)

8. It is the position of the State defendants that the possible loss of FFP through a HEW audit is serious and could result in the withholding of a substantial amount of federal funds. Consequently, the State defendants do not believe that the representations contained in the May 29,

1979 letter assures them that FFP will not be reduced or terminated as a result of implementation of the terms of the stipulation as required in paragraph XIII of the stipulation.

9. While the proposed amendments to the regulations of the New York State Department of Health reflecting the terms of the stipulation were not forwarded to HEW until recently, HEW has had a copy of the stipulation since May 29, 1979. Since HEW has had a copy of the stipulation for almost four months and has had continuing discussions with the parties regarding the stipulation during that time, it is reasonable to believe that HEW has had an opportunity to form an opinion as to whether the terms of the stipulation comport with federal regulations.

10. Upon information and belief, HEW's reluctance to state its views as to whether the stipulation comports with federal requirements is based on HEW's objection to that portion of the stipulation which provides that an adverse utilization review finding is medically contra-indicated where the patient does not voluntarily consent to the proposed transfer. (See Stipulation, ¶ II, F.)

11. Defendants agreed to the inclusion of the provision regarding the necessity of patient consent to transfer for two reasons. First, there exists a widespread phenomena known as "transfer trauma" which is the anxiety experienced by an elderly patient when moved from or even faced with the threat of being moved from a nursing home which he has come to view as his home to another institution. Further, it appears that transfer trauma can cause a deterioration of the patient's health leading in some cases to his death. Secondly, it appears that there is at present no way to know which patients who object to being transferred out of a facility will suffer from transfer trauma and which will not.

Therefore, the State defendants concluded that, given the current state of medical understanding of transfer trauma, the only way to protect the patient's health is to require that he consent to any proposed out-of-facility transfer.

12. If HEW objects to the State's position that nursing home patients ought not to be transferred against their will, now is the time for HEW to present its case. It would certainly better serve the interests of the economical administration of justice if HEW were to be required as a party to the action to either accede to the terms of the stipulation or to present its case against it now and before this Court rather than being able to collaterally attack the stipulation several months or years hence by withholding federal funds from New York State.

13. Furthermore, it is clear that HEW has an interest in this action since the interpretation of federal regulations regarding utilization review are at issue and since federal funds pay for half of the Medicaid program.

14. In the instant motion, plaintiffs, also, seek an order granting summary judgment with respect to two issues of law among those not disposed of by settlement (see Stipulation ¶ VIII, A, 1-2) or, in the event the stipulation is not entered as a judgment, summary judgment as to relief requested by plaintiffs in the joint pre-trial order, as well related permanent injunctive relief. In the event that defendants' motion to join HEW as a party is granted and HEW chooses to defend the action rather than accede to the stipulation, it would seem appropriate for plaintiffs to request this relief in the context of a post-trial motion. Alternatively, should HEW accede to the stipulation or should the Court determine that the State defendants have reduced or terminated so as to

warrant entry of the stipulation as a judgment then there would be no trial and the parties could proceed expeditiously, to submit for the Court to consider the issues of law set forth in ¶ VIII, A, 1-2 of the stipulation.

Therefore, defendants respectfully request that plaintiffs' motion for summary judgment be held in abeyance pending the Court's decision with respect to plaintiffs' motion for entry of the stipulation as a judgment and defendants' motion to join HEW.

WHEREFORE, for the reasons set forth herein, in the accompanying affidavit of Robert F. Skerrett and memorandum of law, it is respectfully requested that plaintiffs' motion for an order directing that the stipulation of consent for entry of partial final judgment be entered as a partial final judgment, pursuant to paragraph XIII of said stipulation on the ground that defendants' compliance with the judgment or any portion thereof will not cause federal financial participation in the New York Medicaid Program to be terminated or reduced be denied and that defendants' motion to join HEW as a party to this action be granted.

s/ KENNETH A. THOMAS

Sworn to before me this
19th day of September, 1979
[Jurat omitted in printing.]

Affidavit of Kenneth A. Thomas in Opposition to Motion for Summary Judgment

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

[Title omitted in printing.]

STATE OF NEW YORK }
COUNTY OF NEW YORK } ss.:

KENNETH A. THOMAS, being duly sworn, deposes and says:

1. I am an Assistant Attorney General in the office of ROBERT ABRAMS, Attorney General of the State of New York, attorney for defendants and I submit this affidavit in opposition to plaintiffs' motion for summary judgment.

2. The joint pre-trial order contains several factual assertions which are disputed by the parties. Factual assertions made by plaintiffs which are disputed by defendants are identified by paragraphs numbered "34", "40", "47", "49e", "54", "58", "77", "80", "83", "85", "87", "89", "90", "91", "105", "106", "110", "112", "115", "121", "129", and "136". Factual assertions made by defendants which are disputed by plaintiffs are identified by paragraphs numbered "9", "14", "26", "28", "35", "46", "49", "49a", "55", "59", "64", "69", "76", "78", "81", "88", "92", "96", "113", "116", "122", "130" and "137".

3. As set forth in the pre-trial order, the disputed issues of fact involve, among other things, the extent to which the utilization review process is now taking into consideration

psycho-social factors in considering whether to recommend transfer of a patient to a lower level of care. Defendants assert that implicit in the UR committee's function is the requirement to consider psycho-social factors which might have an effect on a UR determination. (Pre-trial order, ¶ 35.) If it can be shown that UR committees are adequately taking psycho-social factors into consideration when making a decision on a proposed patient transfer then it can not be said that the UR procedures are per se inadequate. See Pre-trial order, Factual issues underlying plaintiffs' claims for relief No. 5.

4. Plaintiffs contend that the UR committee person who makes an adverse UR decision should be required to personally examine the affected patient. Pre-trial order, page 7. However, if as defendants assert, the nurse who fills out the DMS-1 is often a nurse with first-hand knowledge of the patient's condition, this would be unnecessary. Pre-trial order, page 29.

5. As shown in the Pre-trial order, there is a dispute as to the adequacy of the DMS-1 as an instrument to guide a doctor in determining the appropriate level of care for a patient. Defendants contend that the DMS-1 scoring sheet is a useful tool enabling the better utilization of nursing homes. Pre-trial order pages 50-51. Plaintiffs contend that the DMS-1/UR system does not provide uniform, consistent or adequate assessments of patient needs. Pre-trial order, page 48.

6. The factual disputes set forth above and many others contained in the Pre-trial order demonstrate that there are significant disputed factual issues which require that plaintiffs' motion for summary judgment be denied.

Second Thomas Affidavit

7. One of the issues of law to be submitted to the court for determination in connection with the motion for summary judgment is whether state action is present with respect to UR transfers to higher levels of care. Pre-trial order, page 23.

8. As set forth in the attached administrative letter of defendant New York State Department of Social Services, it is defendant's policy that UR recommendation to transfer a patient to a higher level of care are advisory only. The patient's level of Medicaid reimbursement will not be terminated should he refuse to move notwithstanding a UR recommendation that he be transferred to a higher level of care. See New York State Department of Social Services 78 ADM-31, June 28, 1978 at Addendum #1, Question 1. Consequently, there is no state action present with respect to UR recommendations that a patient be transferred to a higher level of care.

WHEREFORE, it is respectfully requested that plaintiffs' motion for summary judgment be denied.

s/ KENNETH A. THOMAS

Sworn to before me this
10th day of October, 1979
[Jurat omitted in printing.]

Defendants' Rule 9(g) Statement

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

[Title omitted in printing.]

Defendants hereby incorporate into this statement of material facts as to which there is no genuine issue to be tried the statements contained at pages 25-68 of the Joint Pre-Trial Order signed March 5, 1979, except for the following numbered statements: "34", "40", "45", "47", "49e", "54", "58", "77", "80", "83", "85", "87", "89", "90", "91", "105", "106", "110" "112", "115", "121", "129" and "136".

Dated: New York, New York
October 10, 1979

Yours, etc.,

[Attorney's subscription and address omitted in printing.]

Attorney for Defendant

October 17, 1979 Partial Final Judgment

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
Civil Action No. 76 CIV 3360 (CBM)

WILLIAM YARETSKY, *et al.*,

Plaintiffs,

and

MARY FOLEY, *et al.*,

Plaintiffs-Intervenors,

—against—

BARBARA BLUM, *et al.*,

Defendants.

The Court, in January 1978, having found subject matter jurisdiction over this action and having certified this action as a class action, and in January, 1978 having issued a preliminary injunction with respect to certain procedural rights of the plaintiff class to adequate notice and access to medical records prior to hearing review of adverse utilization review decisions concerning patient level of care and level of Medicaid benefits, and the Second Circuit Court of Appeals in January 1979 having affirmed that preliminary injunction insofar as appealed from by defendants (592 F.2d 65), and this Court in June 1978 having issued a declaratory judgment, without injunctive relief, that State Department of Health Hospital Memoranda establishing defendants' utilization review policies and procedures regarding assessment of patient place-

ment needs are invalid for noncompliance with rulemaking requirements of the New York State Administrative Procedure Act (456 F.Supp. 653); and

The parties, by their respective attorneys, having presented for judicial approval the within Stipulation of Consent to Entry of Partial Final Judgment with its Addendum Concerning Monitoring and the Court having satisfied itself as to the fairness, adequacy, and propriety of the proposed Partial Final Judgment and Addendum Concerning Monitoring;

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the Stipulation of Consent to Entry of Partial Final Judgment, with Addendum Concerning Monitoring, annexed hereto is the judgment of this Court.

SO ORDERED. ENTER JUDGMENT.

/s/ CONSTANCE BAKER MOTLEY
U.S.D.J.

DATED: New York, New York
October 17, 1979.

Judgment Entered
10/19/79

s/ RAYMOND F. BURGHARDT
Clerk

Stipulation of Consent to Entry of Partial Final Judgment

IT IS STIPULATED AND AGREED by and between the parties herein, through their respective attorneys, as follows:

I. The parties hereto share a mutual concern for the health and best interests of persons receiving care or services in, or residing in, a facility providing skilled nursing and/or health related care or services in the state of New York (hereinafter "facility"), and further recognize that all the provisions of this judgment, including those concerning the discharge or relocation to a lower level of care (hereinafter "transfer") of such persons (hereinafter "patients") further the best interests of the patients. The parties recognize it is the defendants' position that the considerations and evaluations which resulted in this judgment do not necessarily apply in contexts not within the judgment.

II. No finding, determination or other decision (hereinafter "finding") by a Utilization Review committee or agent, or a person or body performing the function thereof as an agent of defendants (hereinafter "UR" or "UR committee") recommending transfer of a patient to a lower level of care (hereinafter "adverse UR finding"), can be approved or implemented:

A. Unless the UR committee has received and considered:

1. a written and signed psycho-social evaluation indicating the patient's response to possible transfer, and additional written information describing the patient's current physical, emotional and mental condition and treatment plan;

2. a written and signed statement from the patient's attending physician describing the patient's current phys-

ical response to transfer, the current clinical status and whether the transfer is medically safe for the patient and in his/her best interest;

3. a written and signed discharge plan delimiting the proposed placement in sufficient detail to meet the particular placement needs of the patient (e.g., ability of the facility to provide suitable care and services for assessed needs of the patient, geographic constraints, accessibility to family).

B. Unless any medical and nursing portions of the DMS-1 or other assessment instrument provided to and considered by the UR committee is approved and signed by a registered nurse who is directly responsible for the patient's care (this requirement may be implemented by administrative letter).

C. If any assessment instrument or other document forming a basis for the UR committee's finding has an internal inconsistency.

D. If any assessment instrument or other document forming a basis for the UR committee's finding is illegible, partially incomplete, or missing an authorized signature, unless such defect is cured.

E. Unless the appropriate UR procedures established by defendants and described below, were followed, to wit:

1. that, in the case of a patient initially admitted to the facility prior to March 1, 1977 (regardless of intermittant hospitalization or temporary absence), the assessment instrument was not scored and numerical criteria were not applied;

2. that the case was reviewed, in turn, by the UR committee (or a subgroup including at least one UR physician), the patient's attending physician, and, if the

attending physician disagreed with the UR physician, at least one other UR physician after consideration of the attending physician's views;

3. That each person described in subparagraph E.2 *supra*, finds that transfer of the patient to a lower level of care would be proper, as defined in paragraph F *infra*, except for the attending physician in a case where he/she is overridden by a second UR physician.

F. If it is medically contraindicated:

1. An adverse UR finding shall be deemed medically contraindicated unless it is reasonably certain that the resulting transfer is medically safe and in the patient's best interests, and that the proper transfer is suited to the particular needs of the patient;

2. an adverse UR finding resulting in an out-of-facility transfer shall be deemed medically contraindicated unless the patient has voluntarily (i.e., knowingly, willingly and with knowledge of the alternatives) consented to the transfer; provided that transfer within a geographic and operational entity providing both skilled nursing and health related care and services is not an out-of-facility transfer.

(a) Every voluntary consent to transfer shall be accompanied by a dated, written statement: (i) signed by the patient, describing the specific transfer consented to by the patient and reciting that the transfer is voluntary, as defined herein, specifically that he/she understands that transfer will not be required without his/her consent; and (ii) signed by the person designated by the facility or the defendants, certifying that the proposed transfer and available alternatives have been explained to the patient, that the patient understands and voluntarily signed the statement, and that the patient is not unable to consent to the transfer because of confusion or impaired judgment.

(b) If the patient is unable to consent to the transfer because of confusion or impaired judgment, it will be presumed that the patient has not voluntarily consented to the transfer.

III. Patients' procedural rights shall include, but are not limited to, the following items:

A. following adoption or approval of an adverse UR finding, the state or local agency shall provide:

1. timely and adequate written notice of the adverse finding which shall include at least (a) a description of the proposed action, (b) the specific regulations supporting the action, (c) a full explanation of the individual's right to an evidentiary state agency hearing, (d) the procedures for requesting such hearing, (e) the circumstances under which assistance is continued if a hearing is requested, (f) the name, address and phone number where legal services or other representation assistance, if available, may be sought in the patient's locality, (g) a statement of the patient's right of access to his/her records (as described in paragraph E *infra*);

2. a written statement, signed by the UR physician(s) who made the adverse finding, setting forth, in specific detail, the changed medical conditions or other circumstances of the individual which support the adverse finding;

3. a copy of the completed patient assessment form (DMS-1 or form serving the function thereof) used by the UR committee in its review, together with any psychosocial clinical or other addenda.

B. If the adverse finding recommends an out-of-facility transfer (as limited by Section II, F.2, *supra*) the notice described in subparagraph A.1 *supra* shall also include a statement that the transfer cannot be approved or im-

plemented unless the patient voluntarily consents to transfer to a specifically identified facility or facilities or other location.

C. The specific language and form of the notice described in subparagraph A.1 *supra* shall be as agreed to by the parties.

D. A copy of the documents described in paragraph A *supra* shall be provided to the patient, the patient's next of kin or designated representative, the patient's attending physician, and the facility.

E. Every affected patient shall have a fully adequate opportunity, prior to and during the fair hearing, to review an adverse UR finding, to have unencumbered access to, and to review and copy (with the patient permitted to copy without charge a reasonable quantity of documents) the contents of that patient's case file, and all documents and records to be used against the patient at the hearing, all documents, medical or otherwise, which were considered or relied on by the UR committee, and all medical documents and records concerning the patient which are located at the facility where the patient resides, including all so-called "medically contraindicated information" contained in any such documents or records.

IV. Proof of satisfaction of each of the substantive and procedural elements identified in Sections II and III of this decree is a necessary condition for affirmance after hearing of an adverse UR finding. The elements identified in Section II must be proven by testimony at the hearing of a physician or other health professional who participated in making or approving the adverse UR finding and who has knowledge of the facts.

V. To assist facilities and personnel involved in the UR process in the performance of their duties, within 60 days

of the entry of judgment herein defendants shall provide facilities and such personnel with:

A. A UR operations and training manual incorporating all relevant standards and procedures, and

B. a list of adult homes (RCFA's) which are in compliance wtih applicable standards, as determined by the Division of Adult Residential Care of the New York State Department of Social Services (hereinafter "DARC"); no patient may be recommended for discharge to an adult home not on this list without specific waiver from DARC.

VI. The standards and procedures adopted by defendants, which implement the requirements of this decree, shall be promulgated within 60 days of the entry of judgment herein as regulations pursuant to the New York State Administrative Procedure Act to the extent required thereby and unless otherwise indicated herein, and no regulation or procedure shall be promulgated which is inconsistent with this decree.

VII. (This judgment will include provisions to enable adequate monitoring of compliance with the terms of the judgment, the details of which will be agreed upon by the parties prior to submission of the judgment for approval of the Court.)

VIII. Several issues are not resolved by this settlement and are to be disposed of as follows:

A. the following issues are to be resolved by the Court on appropriate motion or hearing:

1. The question of whether there is state action and a constitutional right to a pre-transfer evidentiary hearing in a patient transfer to a higher level of care and/or

a patient transfer initiated by the facility or its agents; and

2. The question of whether, under federal and state law and the Constitution, the State Commissioner of Social Services or the Commissioner's agent may override a hearing officer recommendation in favor of a patient without first having prepared, reviewed, and adequately considered, together with all exhibits, a verbatim transcript of the hearing.

B. Plaintiffs reserve the following issues to be litigated, or, following the period of monitoring described in paragraph VII, *supra,* to be withdrawn without prejudice by plaintiffs:

1. The question of a patient's constitutional right to skilled representatives at state expense (a) at the stage at which the patient is notified of an adverse UR finding and/or is asked to voluntarily agree to transfer, and (b) at a fair hearing to review a UR transfer determination;

2. The question of whether the use of the DMS-1 form and scoring system violates patients' rights; and

3. The question of whether defendants are required to mandate or encourage by reasonable reimbursement incentives, that all facilities provide at least skilled nursing and health related levels of care.

IX. The terms of this judgment shall bind the defendants and their successors in office, their officers, agents, servants, employees and attorneys, and those persons in active concert or participation with them who receive actual notice of this judgment by personal service or otherwise.

X. The issues of the award of reasonable attorneys' fees, costs, and disbursements herein are reserved for later determination by this Court, upon appropriate motion.

XI. Jurisdiction over this suit is retained by this Court until further order (a) for the purpose of enabling any party to apply for an order pursuant to Rule 60 of the Federal Rules of Civil Procedure; (b) for such further orders as may be necessary or appropriate for the continuation, enforcement, or implementation of this judgment or any of the provisions thereof; or (c) for the litigation of issues within the meaning of Section XIII, *infra.*

XII. Except as otherwise provided herein, this judgment shall become effective on the date of entry thereof. All adverse UR findings not implemented by the effective date of this judgment shall be subject to the terms of this judgment.

XIII. Defendants are not bound by and judicial approval of this judgment shall not be sought by the parties until the U. S. Department of Health, Education and Welfare (hereinafter "HEW") represents, or it is judicially determined, that defendants' compliance with this judgment or any portion thereof will not cause federal financial participation (hereinafter "FFP") in the New York State Medicaid Program to be terminated or reduced; except that defendants shall not be bound by this judgment to the extent and during a period that said judicial determination, if any, is judicially stayed or vacated. Any subsequent determination by HEW to terminate or reduce FFP in the New York State Medicaid Program because of defendants' compliance with any part of this judgment shall, upon ten days notice thereof to plaintiffs' counsel, relieve defendants from compliance with that portion of this judgment. In the event that any portion of this judgment is vacated pursuant to this paragraph, plaintiffs shall have the right to litigate in this suit the issues underlying the vacated portion of this judgment.

Dated: New York, New York
May 29, 1979

[Attorneys' subscriptions omitted in printing.]

Attorney for Defendants Attorneys for Plaintiffs

Addendum Concerning Monitoring (to Stipulation of Consent to Entry of Partial Final Judgment)

WHEREAS on May 29, 1979 the attorneys for plaintiffs and defendants in *Yaretsky* v. *Blum,* Civil Action No. 76 Civ. 3360 (S.D.N.Y.), entered into a Stipulation of Consent to Entry of Partial Final Judgment (hereinafter "Judgment");

WHEREAS, paragraph VII of said Judgment stated that "this judgment will include provisions to enable adequate monitoring of compliance with the terms of the judgment, the details of which will be agreed upon by the parties prior to submission of the judgment for approval of the Court"; and

WHEREAS, the parties have agreed to submit said Judgment for approval by the Court on October 17, 1979;

WHEREFORE, IT IS STIPULATED AND AGREED by and between the parties herein, through their respective attorneys, that in order to monitor compliance with said Judgment:

A. Defendants shall obtain, maintain and tabulate

1. data stating the number of adverse UR findings, broken down by:

a. region

b. type of facility (i.e. single or multi-level)

c. recommended level-of-care destination

d. disposition or outcome of the finding, including the number resulting in:

(1) adverse findings which were overridden by defendants or their agent,

(2) transfers which were accepted voluntarily,

(3) transfers which were not accepted voluntarily,

(4) "fair hearing" affirmances,

(5) "fair hearing" reversals.

2. data regarding conformance with the requirements of Section II of the Judgment.

B. Defendants shall provide plaintiffs with the data tabulated pursuant to paragraph A, and any other data compiled or tabulated by defendants in connection with adverse UR findings, at periodic intervals not to exceed four months.

C. Defendants shall maintain copies of every written statement executed pursuant to Section II F.2(a) of the Judgment and every notice of adverse UR finding, with required addenda, provided pursuant to Section III.A., of the Judgment.

D. Entry by the Court of this Judgment shall confirm the right of plaintiffs and/or their designees to have access, at reasonable times and places, and solely for the purposes of the instant lawsuit, to all:

1. data or documents obtained, maintained or tabulated by defendants in connection with adverse UR findings;

2. agents or employees of defendants involved in the operation or monitoring of the UR procedures described in this judgment;

3. patients who are subject to adverse UR findings, as well as said patients':

a. families,

b. facilities,

c. facility staff,

d. physicians,

e. medical and other records.

E. Defendants shall provide plaintiffs or their designees with letters-of-introduction to facilitate access to persons, places and documents described in paragraph D, *supra,* and shall take any other reasonable steps within their authority necessary to facilitate said access, but shall not have any other obligation in connection therewith.

F. Defendants shall have the right to disapprove, upon reasonable grounds, a person or organization chosen by plaintiffs as their designee for purposes of the within monitoring provisions.

G. The within monitoring provisions shall take effect six months from the date that the Judgment is entered, or upon request of plaintiffs, whichever is later, and shall continue for one year thereafter, except that said provisions shall in no event continue in effect for more than eighteen months following implementation by defendants of the terms of the Judgment.

DATED: New York, New York
October 17, 1979.

[Attorneys' subscriptions omitted in printing.]

Attorney for Defendants

Attorneys for Plaintiffs

October 17, 1979 Memorandum Opinion Endorsed[*]

The court holds that as to both non-UR transfers out of a facility or to a lower level of care and as to UR transfers to higher levels of care there is a due process right to a hearing, state action being involved in both instances for all of the reason [sic] set forth in plaintiffs [sic] memorandums [sic] of law on these question [sic] and that it is settled law that a verbatim transcript is required.

Submit Order.

N.Y. N.Y. 10/17/79

s/ CONSTANCE BAKER MOTLEY
U.S.D.J.

Filed Oct. 19, 1979
U.S. District Court
S.D. of N.Y.

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[*] Handwritten endorsement by the district judge on the back of document number 82 of the record on appeal.—ED.

December 13, 1979 Partial Final Judgment

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
Civil Action No. 76 Civ. 3360 (CBM)

WILLIAM YARETSKY, *et al.*,

Plaintiffs,

and

MARY FOLEY, *et al.*,

Plaintiffs-Intervenors

—against—

BARBARA BLUM, et al.,

Defendants.

The Court on October 17, 1979 having ordered the entry as a partial final judgment of the consent stipulation signed by attorneys for the parties on May 29, 1979 together with the Addendum Concerning Monitoring signed on October 17, 1979, and several legal issues having been reserved in the partial final judgment for judicial determination, and the Court having issued a memorandum opinion on October 17, 1979, granting summary judgment in favor of the plaintiffs on the reserved legal issues, it is hereby

ORDERED, ADJUDGED and DECREED (1), pursuant to Rule 23(c)(1) of the Federal Rules of Civil Procedure, that the plaintiff class in this action is defined as all Medicaid recipients in the State of New York who are residents

of skilled nursing facilities or health-related facilities in the State; and it is further,

ORDERED, ADJUDGED and DECREED (2), pursuant to Rule 56 of the Federal Rules of Civil Procedure and 28 U.S.C. § 2201, that the defendants' failure to provide advance adequate notice in writing and the opportunity for a prior evidentiary hearing for each plaintiff class member whom the nursing facility in which he/she resides intends to discharge, transfer to a lower level of nursing care, or transfer to a higher level of nursing care is unlawful under the Due Process Clause of the Fourteenth Amendment; and it is further,

ORDERED, ADJUDGED and DECREED (3), pursuant to Rule 56 of the Federal Rules of Civil Procedure and 28 U.S.C. § 2202, that the action of the defendant State Commissioner of Social Services and her authorized agent in rendering a fair hearing decision unfavorable to a plaintiff class member without first obtaining, reading, and adequately considering a verbatim transcript of the fair hearing, together with all exhibits at the hearing, is unlawful under the Due Process Clause of the Fourteenth Amendment and New York State Law; and it is further,

ORDERED AND ADJUDGED (4), pursuant to Rule 65 of the Federal Rules of Civil Procedure and 28 U.S.C. § 2202, that the defendants, their officers, agents, employees, successors in office and all persons in active concert and participation with them (including all skilled nursing and health-related facilities in New York State) be and hereby are permanently enjoined, in the case of any plaintiff class member, from permitting or taking the action of discharging the patient, transferring the patient to a lower level of nursing care, or transferring the patient to a higher level of nursing care without the provision by the

defendants or their authorized employees of (a) written notice to the affected patient a reasonable period in advance of the proposed action setting forth in adequate detail at least a description of the proposed action and a full explanation of the individual's right to obtain a prior evidentiary state agency hearing to contest the proposed action, and (b) the opportunity for the affected patient to have an evidentiary state agency hearing in advance of the proposed action on the issue of the validity and appropriateness of the proposed action pursuant to applicable federal and state statutory and regulatory provisions (including, but not limited to, 42 C.F.R. §§ 405.1121 (k)(4) and 442.311 (c)); and it is further,

ORDERED and ADJUDGED (5), pursuant to Rule 65 of the Federal Rules of Civil Procedure and 28 U.S.C. § 2202, that the defendant State Commissioner of Social Services, her officers, agents, employees, and successors in office be and hereby are permanently enjoined from rendering a fair hearing decision unfavorable to any plaintiff class member without first obtaining, reading, and adequately considering a verbatim transcript of the fair hearing, together with all exhibits at the hearing; and it is further,

ORDERED (6) that the issue of plaintiffs' entitlement to an award of reasonable attorneys' fees, expenses, and costs herein is reserved for later determination by this Court, upon appropriate motion.

s/ CONSTANCE BAKER MOTLEY
U.S.D.J.

Dated: New York, New York
December 13, 1979

JUDGMENT ENTERED 2/19/80
s/ RAYMOND F. BURGHARDT
Clerk

Notice of Appeal

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

[Title omitted in printing.]

SIRS:

PLEASE TAKE NOTICE that defendant BARBARA BLUM, Commissioner of the New York State Department of Social Services and defendant ROBERT WHALEN, Commissioner of the New York State Department of Health hereby appeal to the United States Court of Appeals for the Second Circuit from each and every part of the partial final judgment entered on the 14th day of February, 1980 granting summary judgment in favor of the plaintiffs on the reserved legal issues.

Dated: New York, New York
March 6, 1980

Yours, etc.,

[Attorney's subscription and address omitted in printing.]

Attorney for Defendants

[Attorneys' names and addresses omitted in printing.]

Attorneys for Plaintiffs
Filed Mar. 7, 1980
U.S. District Court
S.D. of N.Y.

August 25, 1980 Opinion of the United States Court of Appeals

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

No. 1234—September Term, 1979
(Argued June 11, 1980 Decided August 25, 1980)
Docket No. 80-7197

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Plaintiffs-Appellees,

—and—

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY, and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Plaintiffs-Intervenors-Appellants [sic],

—against—

BARBARA BLUM, individually and as Acting Commissioner of the New York State Department of Social Services; ROBERT WHALEN, M.D., individually and as Commissioner of the New York State Department of Health,

Defendants-Appellants.

Before:

LUMBARD and MANSFIELD, *Circuit Judges*, and MEHRTENS, *District Judge.**

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* Pursuant to § 0.14 of the Rules of this Court, this appeal is being determined by Judges Lumbard and Mansfield, who are in agreement on this opinion. Judge Mehrtens, Senior District Judge for the Southern District of Florida who was designated to sit on this case and who heard the argument, unfortunately died on July 16, 1980. Although he concurred in the disposition of this case, prior to his death he did not have the opportunity to see this opinion.

Appeal from a permanent injunction granted by the District Court for the Southern District, Motley, *J.*, requiring the State of New York to furnish certain procedural safeguards to Medicaid recipients resident in nursing homes prior to transfer. Affirmed in part, vacated in part, and modified.

[Appearances omitted in printing.]

LUMBARD, *Circuit Judge:*

Plaintiffs, certified by the district court as that class of persons receiving New York State Medicaid assistance who are residents of nursing homes, were granted a permanent injunction by the District Court for the Southern District, Motley, *J.*, enjoining state authorities and nursing homes from discharging or transferring patients to a different level of care without certain procedural safeguards intended to supplement residents' existing state statutory right of a hearing.[1] Also at issue is the district court's permanent injunction forbidding state officials from reversing a hearing officer decision favorable to a plaintiff class member without having considered the full transcript of the hearing, and the district court's refusal to order the Department of Health, Education and Welfare ("HEW") joined as a party. We affirm the permanent injunction with respect to the due process rights of patients subject to transfer, with some modification; we vacate the district court's injunction with regard to reversals of hearing officer determinations; and we affirm the district court with respect to its refusal to order joinder of HEW.

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[1] At the evidentiary hearing, the patient can challenge his transfer on various substantive grounds derived from state and federal statute and regulations. The most important of these substantive grounds is that his transfer be for "medical reasons".

In the past two decades, government has taken responsibility for caring for the medical needs of the elderly. One result of this has been the creation of a system of nursing homes, owned and run by private individuals or charitable organizations, whose population is made up largely of elderly recipients of state and federal assistance. Nursing homes are classified into two types: skilled nursing facilities (SNF's), and health related facilities (HRF's).[2] The latter provide a lower level of care than the former.

Through HEW regulations, the federal government mandates a procedure called Utilization Review (UR), a kind of patient audit meant to insure that patients are not kept in SNF's longer than necessary, or in any facility when they no longer need medical attention or custodial care. The regulations provide that decisions on such matters are to be made by a Utilization Review Committee (URC), made up, in part, of physicians not financially interested in the affairs of the particular nursing home.

When a patient is transferred from one level of care to another, the State Medicaid authorities review his status and reduce or increase his benefits accordingly and the parties agree that reimbursement rates are "ordinarily" lower for HRF's than for SNF's. A decision to reduce or terminate a patient's Medicaid benefits triggers a federal right (under 42 U.S.C. § 1396(a)(3) and 45 C.F.R. § 205.10) to a hearing, provided by the state. Plaintiffs claimed in this case that the bare right to such a hearing did not meet the requirements of due process, in part because of inherent shortcomings and in part because of the manner in which the state has performed its duty to provide such hearings.

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[2] At the time this case was tried, there were approximately 95,000 nursing home beds in New York state, including approximately 68,000 SNF beds and 27,000 HRF beds. There were 611 nursing homes in the state, of which 291 were SNF's, 30 were HRF's, and 290 were combination SNF-HRF's.

In particular the district court found that patients were not given effective written notice of their hearing rights and were not given sufficient access to their medical files to enable them effectively to challenge the transfer decision.

In an earlier appeal, we affirmed, insofar as appealed from, a preliminary injunction granted by the district court ordering certain additional procedural due process safeguards with regard to nursing home transfers, prohibiting the state from delegating to nursing homes the responsibility for notifying patients of their hearing rights, and prohibiting the state from not dsclosing to the patient medical information deemed harmful to a patient. *Yaretsky v. Blum,* 592 F.2d 65 (2d Cir. 1979).

Before the injunction was made permanent, the parties entered into a consent judgment which embodied most of the procedural safeguards sought by plaintiffs with respect to patient transfers. The consent judgment spelled out the right of the patient or his representative to receive timely notice of the intended transfer; guaranteed the opportunity to have access to all documents in his medical file; made the patient's voluntary permission a prerequisite to transfer; and required that the hearing officer consider a "psycho-social" evaluation of the effect of transfer on the patient.

The consent judgment left several issues of the law to be decided by the district court: (1) are due process protections required (a) when a patient is transferred from a lower to a higher level of care, whether the transfer is initiated by a URC or not, and (b) when a patient transfer to a lower level of care is not initiated by a URC; and (2) are state administrative agency decision-makers required by due process or state law to read a verbatim transcript of the hearing before reversing a hearing officer's determination favorable to a member of the plaintiff class?

The district court found that patients are entitled to due process when transferred from a lower level of care

to a higher one, and when a transfer is initiated by someone other than a URC. We agree because we think such transfers involve state action affecting constitutionally protected property and liberty interests.

The Supreme Court has not defined the limits of state action, but it has supplied the following, somewhat sibylline formula: "the existence of 'state action' depends on 'whether there is sufficiently close nexus between the State and challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself.'" *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 351 (1974), *quoted in Schlein v. Milford Hospital Inc.*, 561 F.2d 427, 428 (2d Cir. 1977). In *Jackson*, the inaction of a state regulatory commission in failing to veto a clause in a utility's tariff was found insufficient to be state action. In *Schlein*, the action of a private hospital in rejecting a physician's application for staff privileges was held not to be state action.

In the case at bar, however, the state takes a less passive role and responds to the "action" of the "regulated entity". When a nursing home moves a patient from an SNF to an HRF, or when a patient is moved by either the nursing home or a URC to an SNF from an HRF, the state Medicaid authorities adjust the patient's benefits. The state has, in essence, delegated a decision to increase or reduce a public assistance recipient's benefits to a "private" party; but such a delegation cannot prevent due process guarantees from attaching. In *Yaretsky v. Blum*, *supra* at 67, we held that the state cannot delegate its due process duty to notify patients of their rights to a hearing.

Appellants argue that when a patient's private physician initiates a transfer of his patient from one level of care to another that cannot be said to be state action. This argument misses the mark, because we do not base our finding of state action on the character of the nursing home in-

dustry as a regulated industry, nor on the function of providing health care for the elderly as a non-delegable duty of the state. A private physician's decision to transfer his patient can have the same result as a nursing home's—an alteration in the patient's benefits. Since that is the nexus required by *Jackson v. Metropolitan Edison,* and since that exists equally despite the change in identity of the party initiating the transfer, no exception can be made for physician-initiated transfers.

Once it is determined that state action has occurred, the second level of analysis is the identification of a liberty or property interest affected by the state action. In *O'Bannon v. Town Court Nursing Home,* 48 U.S.L.W. 4842 (1980), seven justices agreed that nursing home patients did not enjoy a due process right with respect to a decision by HEW to decertify a nursing home. But the *O'Bannon* majority also clearly recognized due process protection for Medicaid patients when the withdrawal of "direct benefits" under Medicaid programs was involved. 48 U.S.L.W. at 4845. These "direct benefits" were characterized by the court as those "essentially financial in character." Thus, in this case, when a patient is transferred from an SNF to an HRF, or from either an SNF or HRF to an adult home providing no medical care, or is simply discharged, a clear property right entitled to constitutional protection is affected. Where a patient is transferred to a higher level of care, there is no similar withdrawal of "essentially financial" "direct benefits." But appellees argue that a patient's interest in avoiding the effects of "transfer trauma" is a constitutionally protected "liberty interest." We agree.

In *O'Bannon v. Town Court Nursing Home,* the majority assumed that "transfer trauma" existed, but reasoned that when such trauma was caused by the action of a third party (i.e., the nursing home) in failing to remain qualified for federal aid, Medicaid recipients did

not suffer a "direct" enough injury to make it a deprivation of life, liberty or property. 48 U.S.L.W. at 4845. We do not believe, however, that *O'Bannon* forecloses the question whether there is a liberty interest in avoidance of transfer trauma in this case. The majority's distinction between those rights of Medicaid recipients which are protected by due process ("direct benefits") and those not so protected ("indirect benefits"), in the context of which the majority's rejection of reliance on transfer trauma as denial of a liberty interest occurs, is prefaced by the important qualification: "decertification . . . is not the same for purposes of due process analysis as a decision to transfer a particular patient. . . ." 48 U.S.L.W. at 4845. Moreover, *O'Bannon* was not decided on the basis of a record that included much detailed information about the existence of transfer trauma, see 48 U.S.L.W. at 4849, n.10 (Blackmun, *J.*, concurring in the judgment), although one justice, relying on extra-record studies, was convinced that the medical evidence was "inconclusive." 48 U.S.L.W. at 4850 (Blackmun, *J.*, concurring in the judgment). We note that the record in this case contains ample evidence that transfer of elderly patients, even when it does not pose an increased risk of mortality, carries with it the undeniable possibility of emotional and psychological harm—at least in the case of many individuals. To us this does not seem any less a "liberty interest" than a prison inmate's interest in not being transferred from a penitentiary to a psychiatric hospital; which interest was accorded constitutional protection in *Vitek v. Jones*, 48 U.S.L.W. 4317 (1980).

Having found that state action and a constitutionally cognizable liberty or property interest exists, it follows that the plaintiffs are entitled to due process. But the question of what process is due them requires further

consideration, particularly where, as here, plaintiffs are already given, by statute, the right to a hearing. *Mathews v. Eldridge,* 424 U.S. 319 (1976), requires a balancing of private interest, risk of erroneous decision, and administrative burdens in formulating the procedural protection required to satisfy due process. We are persuaded that the contours of the relief fashioned by the district court represent an appropriate balancing of the interests recognized in *Mathews.* In essence, the injunction confirms those due process protections already conferred on Medicaid patients by the language of federal and state statutes and regulations already on the books. Under such circumstances, and absent any argument by appellants that the scope of the remedy is too broad, we affirm the district court's injunction under *Mathews.*[3]

Appellants also argue that the district court's refusal to order an appearance by HEW in this case was an abuse of discretion. Since New York State's eligibility for federal funds reimbursing many of the costs of its Medicaid program depends on HEW's determination that state procedures comply with federal regulations, appellants argue that implementation of the court's injunction may jeopardize New York's approved status. Given such a threat, they argue, HEW should have been brought into the case. Whatever the desirability of such participation, see *Yaretsky v. Blum, supra* at 70 (Lumbard, *J.*, concurring in part, dissenting in part), we cannot say that the district court abused its discretion. Present in the record in this case is a letter from HEW acknowledging

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[3] We note that the October 17, 1979 partial final judgment embodying the parties' consent agreement contains procedural protections for patients subject to UR-initiated transfer considerably more extensive than those granted to patients subject to non-UR transfer under the partial final judgment of February 19, 1980. Only the latter has been appealed, and thus we have no occasion to deal with whether or not the protections embodied in the October 17 stipulations are required by due process or satisfy the principles of *Mathews v. Eldridge, supra.*

that the post-injunction state of affairs poses no compliance problem for HEW. However, we think it best to modify the injunction to include a provision that if at any time in the future HEW determines that the procedures mandated by this injunction make New York State wholly or partially ineligible for Medicaid reimbursement funds, upon application, the district court shall vacate the injunction.

Finally we reach the question of the district court's decision that a decision-maker's failure to rely on hearing transcripts violates the Fourteenth Amendment of the United States Constitution and New York law. We hold that neither the Constitution nor New York law requires the administrative decision-maker in an appeal from a hearing officer recommendation to read (or listen to) the entire transcript (or tape recording) of the hearing before issuing an administratively final decision, whether favorable or adverse to the claimant. Accordingly, we vacate the district court's injunction insofar as it affected the state's administrative practice in this regard.

Patients about to be transferred have the right, under federal statute and regulations, 42 U.S.C. § 1396(a)(3) and 45 C.F.R. § 205.10, to a "fair hearing" provided by the state. This hearing is conducted by a hearing examiner who listens to the testimony, prepares a summary, and makes a recommendation to the Commissioner. Although the parties sharply disagree as to whether or not the hearing officer is empowered to make findings of fact, we do not find that issue controlling and do not decide it. The parties agree that the stenographic or electronic transcript of the hearing is sent to the Department of Social Services in Albany, and that the Commissioner's designees who are responsible for deciding the case do not listen to a tape of the hearing, and that no transcript of the hearing is made prior to their

decision. (The chief purpose of the state statutory requirement that a complete electronic or stenographic record of the hearing be kept appears to be to allow judicial review in a proceeding under N.Y.C.P.L.R. Article 78.) The Commissioner's designees follow a set of ten detailed criteria in deciding whether to approve or disapprove the hearing officer's recommendation. If he feels the need, the designee may consult the electronic or stenographic record, but the parties agree that state policy does not require the designee to do so.

We believe that, insofar as federal law is concerned, this issue is governed by *National Nutritional Foods Assoc. v. FDA*, 491 F.2d 1141 (2d Cir. 1974). In *National Nutritional*, an FDA regulation was challenged on the ground that the Commissioner who signed the order involved could not possibly have reviewed and considered objections to the proposed rule because of their volume during the short period he had been in office at the time he approved the regulation. Like appellees in this case, petitioners in *National Nutritional* relied on *Morgan v. United States*, 298 U.S. 468 (1936) (Morgan I), which contains the familiar phrase "The one who decides must hear." *Id.* at 481. But, as Judge Friendly's opinion in *National Nutritional* observes, "the life of this aspect of Morgan I was extremely brief. In Morgan IV [*United States v. Morgan*, 313 U.S. 409 (1941)] Mr. Justice Frankfurter, writing for a Court unanimous on this point, took back most or all of what the first decision had given." 491 F.2d at 1144.

Even the Morgan I case cannot be said to go as far as appellees would argue. As Professor Kenneth Culp Davis has written:

> Since the only purpose of sifting and analyzing of evidence by subordinates is to save the time of the deciding officers, this necessarily means that deciding officers may "consider and appraise" the evidence by reading a summary or analysis prepared by sub-

> ordinates. The Supreme Court thus did not require in the First Morgan case that deciding officers must read all the evidence or even that they must directly read any of it. The requirement has to do with personal understanding of the evidence, not with the mechanics by which the understanding is developed. In common practice, deciding officers develop their understanding of evidence not only through reports of subordinates but especially through summaries and explanations in briefs. . . .

2 Davis, Administrative Law § 11.03 at 44-45 (1958) (footnotes omitted). See also *Bates v. Sponberg*, 547 F.2d 325 (6th Cir. 1976) (no violation of due process when decision-making body voted on appeal from an administrative adjudication without reading the transcript, relying on summary report).

Under Morgan IV and *National Nutritional*,[4] an administrative official to whom a decision has been delegated is immune from judicial inquiry "as to the extent of his investigation and knowledge of the points decided, or as to the methods by which he reached his determination."[5]

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[4] In *National Nutritional*, our opinion emphasized that the "presumption of regularity" in the actions of administrative decision-makers is especially appropriate 'in the context of the promulgation of legislative rules as distinguished from adjudication," 491 F.2d at 1145. The resolution of appeals in nursing home transfer cases is, of course, administrative action of an adjudicative rather than rule-making type. We see, however, no reason for adopting a different rule in the adjudicative context. Under *Mathews v. Eldridge, supra*, the administrative burden on the state may be given weight in determining the boundaries of due process protection in both adjudicative and rule-making proceedings; indeed, *Mathews* itself involved an adjudication. *Bates v. Sponberg*, 547 F.2d 325 (6th Cir. 1976) also involved an adjudication.

[5] An exception to this general principle exists where there is a showing of misconduct on the part of the agency. *See, e.g., Singer Sewing Machine Co. v. NLRB*, 329 F.2d 200, 206-08 (4th Cir. 1964).

National Nutritional, supra, 491 F.2d at 1145, quoting *DeCambra v. Rogers,* 189 U.S. 119, 122 (1903). The reasons for this rule derive from the extended, complex nature of the administrative decision-making process, *see Citizens to Preserve Overton Park, Inc. v. Volpe,* 401 U.S. 402, 422-23 (1971) (Blackmun, *J.*, concurring), the difficulty of seeing into the decision-maker's mind, and the enormous volume of administrative decisions which must be made each year. Although, for example, only about 600 appeals from nursing home transfer cases are decided each year in New York State, approximately 68,000 appeals in welfare benefit adjustment cases must be decided in the same period in New York. Such a large administrative burden is an important factor in determining what kind of due process protection must be accorded the subjects of administrative decision-making. *Mathews* v. *Eldridge,* 424 U.S. 319, 335 (1976).[6]

Appellees also argue that New York law prohibits the administrative practice at issue, citing *La Valle v. Blum,* 67 A.D.2d 708 (App. Div. 2d Dept. 1979), *Anderson v. Toia,* 59 A.D.2d 1024 (App. Div. 4th Dept. 1977), *Halley v. Lavine,* 47 A.D.2d 945 (2d Dept. 1975), *Cruz v. Lavine,* 45 A.D.2d 720 (App. Div. 2d Dept. 1974). Some of these intermediate appellate memorandum opinions are distinguishable on their facts; for example, in *Anderson, supra,* the fatal defect in administrative procedure seems

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[6] Appellees rely also on *Ostrowski v. City of New York,* 601 F.2d 629 (2d Cir. 1979), which involved a due process challenge to the decision-making procedures used by the Department of Sanitation in disciplinary cases. But the remarks we made concerning federal due process issues raised by the Department's practices in *Ostrowski* were dictum, since the case was remanded for findings on state law issues. In any event, as the *Ostrowski* opinion notes, the decision-maker in that case "did not have a complete record of hearing." *Id.* at 631. As noted above, the decision-makers in nursing home transfer cases have available to them the complete record of the hearing.

to have been the fact that "the recording tape ran out" during the recording of the hearing, rather than that the agency decision-maker failed to listen to the tape. And *La Valle v. Blum, supra,* is most fairly read as standing for the principle that where an agency determination rests on certain facts which are incorrect and which can be found in correct form in a transcript unread by a decision-maker, a court will grant relief under N.Y.C.P.L.R. Art. 78. But *Halley v. Lavine, supra,* does unequivocally hold that administrative decision-makers must hear or read verbatim transcripts or recordings of fair hearings. *Accord, Cruz v. Lavine, supra.* Whether these memorandum decisions represent a developing trend among New York's intermediate appellate courts is something the future will reveal.

Appellants argue that controlling decisions of the New York Court of Appeals unequivocally show that there is no state law requirement that decision-makers read transcripts, whatever the status of lower court decisions possibly in conflict with the Court of Appeals cases. The first of these cases, *Matter of Weekes v. O'Connell,* 304 N.Y. 259, 107 N.E.2d 290 (Ct. App. 1952), offers little support to appellants. In *Weekes,* the State Liquor Authority adopted and affirmed a hearing officer's decision in a license revocation case within an hour of the conclusion of the hearing, before the hearing had been transcribed. The Court of Appeals, in an opinion by Chief Judge Fuld, held the Authority's decision invalid. Seven years later, however, in *Matter of Taub v. Pirnie,* 3 N.Y.2d 188, 144 N.E.2d 3 (Ct. App. 1957), the Court of Appeals, again in an opinion by Chief Judge Fuld, limited *Weekes'* significance. *Taub* involved a challenge to a decision by a Zoning Appeals board based on the fact that one member of the board had voted without reading a transcript of the hearing held in the case. Judge Fuld wrote:

> Courts, we have said, will not " 'probe the mental process' " of the members of an administrative

> tribunal. Absent a showing, "clearly reveal[ed]," that "they made no independent appraisal and reached no independent conclusion," we will not disturb the decision. As we wrote in the *Weekes* case, "the extent to which independent study of the evidence in the record is necessary to the required exercise of informed judgment must be left to the wisdom and practical good sense of the commissioners themselves" . . . .

3 N.Y.2d at 193-94.

In the Court of Appeals' most recent case in this series, *Matter of Wallace v. Murphy,* 21 N.Y.2d 433, 235 N.E.2d 759 (Ct. App. 1968), involving disciplinary action against a police officer, the Court reiterated its adherence to the *Taub* doctrine that what is required by law (absent specific statutory provisions requiring more) is only an informed decision, and confirmed *Taub's* interpretation of *Weekes* as resting on the Liquor Authority's violation of its own rules and regulations. *Id.* at 438. *Wallace* further held that where state law requires a full transcript to be made, that transcript must be "available" to the decision-maker. But *Wallace* does not hold, and we think the implication is fair that it holds to the contrary, that the decision-maker must take advantage of the transcript's availability in any manner more specific than that required to satisfy *Taub's* mandate of an exercise of "informed judgment".

The Department of Social Services' present practices, as the parties have stipulated, clearly comport with state law requirements that administrative decision-making be an exercise of "informed judgment." The use of the detailed criteria followed by the Department indicate that the decision-maker does much more than rubber-stamp the hearing officer recommendation, and his reliance on summaries and other material prepared by the hearing officer satisfies the state law requirement that his judgment be

informed. Moreover, it is clear that *Wallace's* requirement that where transcripts exist they be available to the decision-maker is satisfied by the Department's practices. The parties have agreed that the electronic recordings of the hearings are forwarded to the Department in Albany, where the decision-maker works. The Department's policy is to have its decision-makers review the electronic transcript only if they feel it would be useful. This practice establishes that the decision-makers have the transcripts "available" in the sense required by *Wallace*.

Accordingly, we reject appellees' argument that state law requires administrative decision-makers to read or listen to complete transcriptions or recordings of hearings before reversing hearing officer recommendations favorable to recipients of benefits conferred by the state.

Affirmed in part, vacated in part, and modified.

February 18, 1981 Order of the United States Court of Appeals Denying Rehearing

UNITED STATES COURT OF APPEALS
SECOND CIRCUIT

At a stated term of the United States Court of Appeals, in and for the Second Circuit, held at the United States Court House, in the City of New York, on the 18th day of February, one thousand nine hundred and eighty-one.

UNITED STATES COURT OF APPEALS
Filed
Feb 18 1981
A. Daniel Fusaro, Clerk
Second Circuit
No. 80-7197

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Plaintiff-Appellees,

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Plaintiffs-Intervenors-Appellees,

v.

BARBARA BLUM, individually and as Acting Commissioner of the New York State Department of Social Services, ROBERT WHALEN, M.D., individually and as Commissioner of the New York State Department of Health,

Defendants-Appellants.

Order Denying Rehearing

A petition for rehearing containing a suggestion that the action be reheard in banc having been filed herein by counsel for the defendants-appellants, Barbara Blum, et al.

Upon consideration by the panel that heard the appeal, it is

Ordered that said petition for rehearing is DENIED.

It is further noted that the suggestion for rehearing in banc has been transmitted to the judges of the court in regular active service and to any other judge on the panel that heard the appeal and that no such judge has requested that a vote be taken thereon.

/s/ A. Daniel Fusaro
Clerk